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CONGRESS OF

PSYCHIATRY

Canadian Psychiatric Association Journal

Vol. 6 Ottawa, Canada, June 1961 No. 3

Editorial

CANADA'S NEED FOR PSYCHIATRISTS

How many graduates of Canadian medical schools are presently undertaking training abroad for the specialty of psychiatry? If anyone can answer this question can they also say how many, upon completion of their training, intend to return to Canada to practise. It is reported that a greater proportion of graduating physicians than formerly are entering psychiatry. It is apparent that far more Canadians obtain this training in the U.S.A. than in Canada. The reason for this is primarily the higher training stipends offered and secondarily the allure of greener pastures. Provided that the training adequately meets the standards of the Royal College of Physicians and Surgeons of Canada the present situation could operate to our advantage. Certain difficulties must, however, be considered. The physician has often completed the standard three year U.S. residency program and requires a fourth year of supervised practice before he is eligible to sit his Canadian specialty examinations. Often he would prefer a full time appointment during this period. Canadian salaries for physicians at this level of training are often less than the physician previously received as a resident while away. Moreover there is a natural reticence on the part of employing agencies to engage, for a year or two, psychiatrists who indicate they are not interested in a life-time career. Some of these physicians have a definite idea of where they wish to settle and most have an inclination toward, at least, some private practice.

On the other hand many have gained interests and skills which can be best practised and developed in institutional settings e.g. group work with adolescents, family care, preventive geriatric programmes. Would a vigorous approach encourage and stimulate some of these physicians to contribute in a major way to mental hospitals and community mental health services? The need is great—roughly forty to sixty new psychiatrists are required annually to meet retirements and maintain present levels of clinical services to these centres.

In metropolitan areas a positive approach to staffing most clinical services by sessional appointments of half time or more would seem relatively simple, since there are few such areas in Canada which do not offer concomitant opportunities for part time private practice at present.

In communities of 15,000 to 100,000 population, where there are understaffed major mental hospitals, the responsible authorities might explore, in advance, opportunities for private practice and general hospital affiliations on a part time basis, to place before trained applicants who would be prepared to spend most of their time in clinical work at the mental hospital.

Measures such as these should not be looked upon as expediencies to deal with short-term manpower emergencies but as steps to an improved pattern of care on a permanent basis for the future.

F.C.R.C.

RESEARCH IN PSYCHIATRY

OSKAR DIETHELM, M.D.[1]

In reviewing the present status of research in the broad field of psychiatry, one must accept the general principles which apply to all kinds of scientific investigation. In addition, there are special principles, particular to psychiatry and often different from those of medical research, which must be recognized. I shall present some of them briefly. In the detailed discussion, I shall illustrate with examples from current and past investigations of the group at the Payne Whitney Psychiatric Clinic.

Psychiatric disorders are not so well defined or circumscribed as physical pathologic changes. The individual aspect of the person involved will give its coloring to all psychopathologic manifestations, sometimes markedly, sometimes little. The picture becomes more obscure when we consider psychiatric illnesses, and not mere groupings of symptoms or syndromes. These illnesses are not readily acceptable entities. They lack clear boundaries and their essential characteristics are disputed. The best known examples are schizophrenic illnesses, but even the manic-depressive psychoses and other affective illnesses frequently present individual features which make a definitive diagnosis difficult, if not impossible. Furthermore, the diagnostic evaluation depends on the observer's theoretical concepts. It is therefore quite possible that an excitement with elation, some fear, confusion, and projection may be considered by some a manic excitement, by others, a schizophrenic excitement with affective features, and by a third group, a paranoid excitement. It is obvious that one cannot merely study a group of patients who have a common diagnosis without attempting to clarify and describe what they have in common, in what way they differ, and individual patterns of normal and pathologic behavior.

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Another difficulty arises from the cultural influences which may modify the psychopathologic picture. It is accepted and easily demonstrable that marked differences may exist in the psychopathologic manifestations of rural and urban populations, and of highly educated and illiterate groups. Even in the same group the frequency of some psychopathologic symptoms and of psychopathologic characteristics may vary greatly during a relatively brief span of time. Involutional melancholia as described by Dreyfuss in Germany and by August Hoch in the United States, which was frequent at the beginning of the present century but has become a rarity, may serve as an example. Depressive illnesses still occur in that age group, but they are not showing the described characteristic symptoms.

Interesting clinical observations are the psychopathologic characteristics of individual patterns which are revealed in each recurrent illness. These individual patterns are most frequently observed in depressive reactions, e.g., in thinking difficulties such as confusion or perplexity. However, the same disorders of thinking may occur in any other psychopathologic disorder.

I am presenting this discussion to illustrate the difficulties one encounters in defining psychiatric illnesses. It is therefore impossible to accumulate valid observations in a group of patients suffering, according to diagnosis, from the same psychiatric illness, draw far-reaching conclusions and apply them to another group of similar patients studied by an investigator with a different psychiatric background or to patients from different sociocultural settings. To a limited extent only, is a critical evaluation of such findings possible.

Psychiatric disorders have their psychologic, physiologic, and sociocultural components. In many investigations one

may focus on any one of these aspects by limiting the research project accordingly. If one wishes to go beyond these boundaries it will be necessary to develop a cooperative investigation in which representatives from other fields will participate. According to the type of investigation and the phase of the study, the psychiatrist may be the leader; or, at other times, the investigator from one of the other fields, may head the study.

All psychiatric investigation must have a dynamic psychopathologic basis. The modern concept of psychopathology accepts both aspects, the overt and the covert. The overt data can be studied directly by the observer and, within limits, objectively described. Yet the subject's description of his experience, especially with regard to emotions, offers an important amplification. The covert aspect of psychopathologic experiences or observations is formed by conscious but unrecognized, or unconscious and indirectly experienced, dynamic factors. Both the overt and the covert are the inseparably linked aspects of a psychopathologic phenomenon. In any investigation one must therefore study carefully everything which can be observed directly as well as the dynamic factors, be they psychologic, physiologic, or environmental. It is essential that all observations be carefully described so that the data obtained are meaningful and useful to other investigators.

The charting of behavior is essential, but even experienced observers will not always agree on what they observe or how it should be charted. From a study of our patients carried out by F. F. Flach, and from a similar study by J. L. Dowis at the University of Florida Medical School, several pertinent facts have become obvious. The observer may encounter difficulties because he does not understand the concept involved or he may not be well enough educated to recognize certain psychopathologic findings, e.g., hallucinations. He may react with emotional involvement to certain tasks, e.g., evaluating patient's truthfulness. In charting eroticism he may be influenced by his own reaction to the patient's erotic behavior or by the need to pass judgment. All these difficulties impair the value of the various behavior charts used in research. They may become valuable aids with further improvements which will make them statistically valid, but they will never completely replace the psychopathologically trained investigator's own observations of the overt findings.

Previously, a reference was made to the coloring of all psychologic and psychopathologic manifestations by the individual aspects of the person involved. Everybody has characteristic patterns of behavior, biologically and psychologically. They may be genetically influenced, but the most important of these influences are related to life experiences and persistent dynamic factors. It would be impossible to investigate them satisfactorily in one experiment carried out on one patient. We can, however, obtain a satisfactory understanding of these behavior patterns if we study the patient repeatedly over a sufficient length of time. Such use of a patient as his own control is essential in the study of psychopathologic and physiologic relationships. In patients who are inadequately aware of their emotions and do not display them freely, it is most difficult to investigate the relationship of emotions and physiologic findings. To this group belong many patients who react with resentment to life situations. In our study of chronic alcoholism we found a group of patients who, after a period of several weeks of abstaining, gradually began to show increasing resentment which, after a marked intensity had been reached, led to the consumption of alcohol. At this time the resentment disappeared, but after one to two weeks the emotional reaction of resentment began to appear again. The patients seem to be unaware of this behavior pattern and neither they nor their families had found a satisfactory explana-

tion for the dependence on alcohol which they had developed. In the study of these patients during enforced periods of abstinence for several months in the Payne Whitney Clinic we became aware of the psychodynamic factors leading to resentment and of minor behavior changes which in these patients indicated underlying resentment. These observations were supported by findings in the Rorschach test, administered two to three times to each patient by the late Emil Oberholzer. Each week, blood was taken for a bio-assay experiment by a pharmacologically trained internist who found certain reactions in the blood assay, their intensity paralleling the intensity of the resentment. The independently-made observations were compared periodically by internist and psychiatrist.

Based on these studies, a rule was formulated in our group that all intensive investigations of emotional and physiologic relationships are to be studied by following the patient over a considerable length of time, using him as his own control. The same procedure must be used if one studies the relationship of emotions and thinking disorders. As emotions always play an active role in a person's life, it can be stated that in all intensive studies, whether they be related to psychologic or physiologic changes, the patient should be used as his own control.

There are some basic difficulties in research in psychiatry. A very troublesome one lies in the use of controls. One rarely has an opportunity to study the individuals who form the group of controls. Through epidemiologic studies by psychiatrists one has become aware of the high percentage of psychopathologic findings in a given population (T. A. C. Rennie and A. H. Leighton). It is therefore unjustifiable to compare psychiatric patients and normal persons, or psychiatric and non-psychiatric cases. All we can state is that we are comparing persons who have either come to the attention of a psychiatrist, or who have not, as far as is known. Many scientific studies in which this faulty use of control has given the investigator an unjustified feeling of security have been published. Statistical methods are valuable but they cannot offer a basis for the type of intensive study of individual patients needed for progress in psychiatric research.

Another difficulty arises in psychiatric research in the application of experiments with animals. Psychologic experiments have offered a certain amount of valuable information but it is exceedingly small when compared to the information obtained in physiology. The study of emotions, one of the basic problems in psychiatry, can be advanced little beyond its present status without new techniques or much more accurate knowledge of the characteristics of different types of emotional reactions. Even then, some emotions cannot be produced in animals because they involve a thought component, as in the emotion of resentment. In recent years, progress made in experiments on monkeys and apes is encouraging, and modifications of some experiments might well become applicable to studies in psychopathology.

Psychologic experimental contributions to psychiatry have not been considerable because interest has been directed overwhelmingly toward the study of dynamic analysis. In this field, great advances were made in the first part of this century and a wholly new orientation has been given to psychopathology, but experimental proof has been most difficult to obtain. The role of emotions has been greatly emphasized, but with an increasing tendency to accept anxiety as the exclusive basic emotion. There has not been sufficient interest to determine whether anxiety is always the same kind of emotion whether found in psychopathologic or non-psychopathologic states. Furthermore, it should be established whether or not anxiety in psychoneurotic, schizophrenic or depressive illnesses is the same.

These critical remarks should not imply that no progress has been made in the last 35 years. Previously, emotions had been classified simply from a behavioristic standpoint. The difference between a normal and pathologic emotion was explained on a quantitative basis. Later, the duration of the affect and the degree of fixity were added. Then the dynamic aspect of emotions received increasing impetus, and the overt aspects became neglected. For example, one still knows very little about the significance of retardation in depression, or the lack of spontaneity or disturbances in attention. The importance of the existentialistic approach in psychopathology is unclear. It has enhanced the value of the subject's experience and the meaning of the emotion to him. The most desirable approach to the study of emotions is that which combines the study of overt behavior with that of the dynamic factor, with the inclusion of the subject's analysis on experiencing the emotion and its meaning to him. Further progress is also needed in the study of other psychologic functions.

It is unfortunate that many times promising psychologic experiments are developed prematurely into tests which may be of value to the clinician in his diagnostic studies and therapeutic considerations but which add little to psychiatric knowledge. The desire of the clinician for better diagnostic and therapeutic tools is understandable but regrettable if it leads to a curtailment of research.

It is difficult, at present, to evaluate the potentialities of Pavlovian theories and procedures in psychopathology and clinical psychiatry. His contributions have been limited as far as one can judge from literature, but little is available from Russian psychiatry which has continued to follow Pavolv's thoughts.

Research in psychiatry depends on the progress of biology and medicine in general and on current philosophical thinking and cultural influences. Psychology may be considered its basic science but physiologic progress has a great influence. The great advances in physics and chemistry and in physiology have opened new vistas in psychiatric investigation. Increased knowledge in endocrinology is especially stimulating to psychiatric investigators. Many problems which can be investigated by modern procedures have been anticipated by outstanding clinicians such as Kraepelin and Jung. In the discussion of research in clinical psychiatry I shall return to this topic.

The pharmacologic contribution to the treatment of psychiatric patients has been, and still is, one of the great advances in psychiatry. A more somber attitude, however, is indicated when one reviews the scientific progress in this field. Like all physicians, psychiatrists are primarily interested in the study and treatment of patients and only a very small number have a keen desire to further knowledge. Much of the recent progress is pragmatic and frequently uncritical, without a sound basis in knowledge. Mistakes, such as confusing visual hallucinations produced by drugs in an experiment in schizophrenia, seem to have been corrected. The main criticism that most pharmacologic studies in psychiatry are not combined with carefully planned psychopathologic investigations remains valid.

Studies in genetics have long been neglected because of psychiatrists' overwhelming interests in psychodynamics. Kallmann's work is a rare exception. The future looks more promising as the successful breeding of monkeys with many of the findings of experiments on monkeys offering a basis for application to psychiatry.

The socio-cultural aspects have demanded increased attention. Progress in methodology and knowledge in sociology and cultural anthropology have made investigations possible in the epidemiology of mental disease. The emphasis is on the effects of environment on psychi-

atric disorders. Studies have been started in several countries in rural and urban districts but, at the present stage of research in social psychiatry, it is still impossible to single out the findings which are basically important for supporting mental health. It will be a long time before the knowledge in this field can be applied to the formulation of plans leading to the maintenance of mental health and prevention of psychiatric illnesses. However, there is always the danger that, because of the immensity of the problem of mental disease and urgency in the need for help, tentative and very limited results will be generalized and used for mental health planning. It is also possible that research programs are too ambitious and try to encompass such a wide field that the data obtained are unwieldly for a proper analysis. In some such studies there has been a tendency to lose sight of the fact that one deals primarily with psychiatric and public health problems in which the sociologic contribution can and must be considerable but cannot replace the psychiatric contribution.

The studies of psychiatric illnesses in different cultures is very interesting and important for the clarification of the influence of cultural-environmental factors on psychopathology and mental health. Thus far, critically collected and studied data have been few and scientific results meager. On the other hand, the possibilities of fruitful investigations have become clearer and scientific analysis may soon replace stimulating speculation.

Clinical research has been mentioned repeatedly in connection with investigations in social psychiatry, of emotional and physiologic relationships, and physiologic and pharmacologic studies. It is therefore necessary that space now be given to a review of work done in psychopathology and clinical psychiatry. It has been stressed before that psychopathology is basic for the study and treatment of any kind of psychiatric illness. The importance of experimental and clinical work in psychopathology has long been recognized, but nevertheless, vast fields have remained untouched. There are, e.g., many psychopathologic disorders which have not as yet been singled out and well described. Concepts which are used freely have not been reformulated and well defined or tested experimentally. Before I offer some examples, I wish to review briefly the concept of personality and its development. We still have not succeeded in proving or disproving, or even elucidating, some of Freud's theories of the infancy period. It is quite possible that the new approach of psychologists in the upbringing of infant monkeys may offer more pertinent data than the careful and minute observations of human infants which has been carried out in the past.

A great many careful observations on clinical material and dynamic investigations are necessary to offer us a much needed understanding of the development of personality and the factors which lead to delay in, or prevention of, reaching a mature organization. It is also insufficiently known what factors, be they psychologic or physiologic, can disorganize a personality, e.g., in a schizophrenic illness. The symptoms of disorganization and of insufficient organization are not well understood, physiologically or psychologically. Better understanding is needed of the effect of the setting of personality organization on the manifestations of a psychiatric disorder. The problem of a clinical evaluation of whether the data available indicate a schizophrenic disorder or the behavior of a poorly-organized psychopathic personality is known to every psychiatrist. We cannot even decide definitely whether we deal with the development of a schizophrenic illness in a psychopathic personality or whether the psychopathic behavior was not already a schizophrenic manifestation. A similar question was posed by Bleuler and Kraepelin 40 years ago; i.e., "is the poor intellectual performance in a person who later develops

a schizophrenic illness the result of the schizophrenic disorder, or is it to be considered an independent manifestation and the schizophrenic illness superimposed on it?

In the field of psychopathology there is a wide group of promising topics which very much need to be studied. In many of them we do not even have a good description of the clinical picture; in others, tools are available to investigate them. In still others, new research procedures could be found to increase our knowledge. The current trend to think of research in the sense of experiments and laboratory studies is highly commendable but one should not overlook the fact that there are important clinical observations to be made. Their value may overshadow much of the experimental work carried out with much expenditure of personnel, time, and money.

For many years my colleagues and I have been troubled by the understanding and treatment of excitements, characterized by a display of sexual activity, including erotic or vulgar talk, exposing oneself, homo- and heterosexual advances and masturbation, by anger, fear, elation, thinking disorders, and often suspiciousness and paranoid delusions. When we began to study them closely, we found a well-defined psychopathologic reaction which resembled a panic state but was fundamentally different because of the dominating feature of sexual activity and the absence of fear as a leading feature. Further studies by T. Van Allen brought out varying degrees of sexual excitement and psychopathologic sexual unrest in schizophrenic, affective, and psychoneurotic illnesses; and psychologic experiments and physiologic investigations in steroid metabolism and enzymes are being undertaken by C. D. Burrell and J. F. Reilly, Jr.

The value of psychologic investigations in intellectual deterioration is demonstrated by C. A. Knehr who, through a group of tests, was able to differentiate between diffuse cortical damage of cerebral arteriosclerosis and multiple sclerosis. The work needs to be continued in many directions but what I wish to point out is that a frequently observed psychopathologic change, intellectual deterioration, has attracted little attention and curiosity.

In thyroid investigations by F. F. Flach, P. E. Stokes and R. W. Rawson, it was found that the administration of triiodothyronine might decrease the distressing experience of depersonalization and stimulate apathetic schizophrenic patients. The interesting biochemical findings were increased calcium excretion. However, the investigators also became aware of the need to study apathy and depersonalization psychopathologically on these patients in the metabolic unit of the Payne Whitney Clinic. Apathy, e.g., which is diagnosed frequently by clinicians, is not described clearly and in sufficient detail in psychiatric literature and very little is known about the psychodynamic and physiologic aspects. These examples illustrate the demanding need to increase our knowledge so that one is able to differentiate various aspects of a psychopathologic finding so that it is possible to compare it with the parallel detailed findings in the chemical laboratory.

An interesting example of the possibility of research in psychiatric illnesses is offered by depressive illnesses. They have been described and etiologically grouped, but never satisfactorily defined. It is unknown whether the essential feature is a depressed mood or the attack form of the illness. It is also unknown what psychologic or physiologic factors may interfere and lead to chronicity. Among the symptoms stressed is retardation, a concept presented over half a century ago, supported by, for that time, good clinical description and psychologic experiments. Later psychodynamic investigations have thrown considerable doubt on the original concept and the need to stress additional emotions, such

as anxiety and resentment. The topic has not been pursued further.

In research in treatment, great effort is directed at refinement of techniques and not enough at obtaining some understanding of the essential factors involved. For instance, on a pragmatic basis, convulsive therapy has been introduced and has become successful, but little is known about the psychologic and physiologic changes which occur. In metabolic studies, F. F. Flach and P. E. Stokes found that patients suffering from depression showed a significant decrease in urinary calcium with therapeutically effective electric convulsive treatment. In another group the calcium remained unchanged by the therapeutically ineffective convulsive therapy.

In recent years much progress has been made in the use of drugs in psychiatry, but the actual psychopathologic reaction involved and the explanations of their therapeutic effectiveness have not received much study. A related topic is research in drug addiction and alcoholism. Progress has not been satisfactory because the patient's personality organization and his psychopathologic condition have not received enough attention. In alcoholics, for instance, little is known about drinking patterns. Recently, in connection with investigations into certain metabolic aspects of alcohol in alcoholic patients, we gave the patient alcohol intravenously. In this controlled state of intoxication, we were able to see the patient's behavior and to use it for psychodynamic investigations. The behavior corresponded to the behavior pattern of his daily life when drinking. Similar experiments have been carried out elsewhere in connection with morphine and other alkaloids, but the patients were not studied sufficiently from a psychiatric point of view and the results therefore have been limited to some chemical aspects which did not throw much light on the problem of drug addiction.

The course of a psychiatric illness needs to be studied much more intensively. In state hospitals it is possible to study the natural course of the illness in schizophrenic patients. In such studies the diversity in etiology frequently becomes obvious, and psychogenic, exogenic, and essentially genetically-determined schizophrenic illnesses can be separated. In many patients the diversity in symptomatology and the groupings in catatonic and paranoid syndromes become clear when one follows the case over a period of years. Another point which needs to be investigated is the diversity in a progressive illness. We may be dealing with a process of deterioration which starts in adolescence and progresses uninterruptedly and which is different from the circular type of schizophrenia. In some cases, affective components strongly color the picture. The onset may also be of significance, especially in the so-called late schizophrenias around the age of 40 to 50.

In concluding, I shall summarize briefly some essential points as they apply to small teaching hospitals and large psychiatric institutions. It is obvious that intensive psychodynamic, physiologic, and experimental investigations are best carried out in teaching centres with their large staffs, well-equipped laboratories and the readily available help from research workers in the many departments of a medical school and university. I shall present as an example the development of research in the teaching institution I know best—the Payne Whitney Psychiatric Clinic. In the beginning, all efforts were directed at establishing and furthering a strong clinical department. The study and treatment of the individual patient was based on dynamic psychopathology. An experimental psychology department was considered an early need, followed by the development of physiologic and pharmacologic investigations. The next step was the building of a metabolism unit which became one of the foci for combined studies by psychiatrists, psychologists, endocrinologists, and pharmacologists. The social aspects

received increasing attention and research work in social psychiatry evolved. A subdepartment of the history of psychiatry was the final step, which will lead to much needed knowledge in the evolvement of clinical and investigative psychiatry. Increasing historical knowledge offers leads and guidance and the sharpening of a critical attitude.

In large psychiatric hospitals investigative potentialities become available through a large variety of cases, an opportunity to study the natural course of an illness, and material for statistical confirmation. The study of environmental factors, especially reactions to hospital procedure and to large groups of patients offers possibilities for the understanding of psychopathologic adaptations. In these large hospitals, special psychopathologic reactions can be observed and related to post-mortem studies.

Progress in research in psychiatry has been considerable during the past half century. I wish to review this progress briefly lest it seem from my critical review that I deprecate the achievements of the past. Ever since the writings of the Greek physicians, followed by the Romans and Arabs and the great clinicians of the Renaissance periods, as well as the internists of the succeeding centuries, clinical observations have steadily augmented the knowledge of psychiatric illnesses. With the development of medical research, a parallel development took place in psychiatry. In the last century, the main progress occurred in relation to the histopathology of the brain; in this century, in psychopathology and physiologic studies. The great impetus was given by Freud in his psychoanalytic investigations and formulations and their application by Bleuler and Jung to schizophrenic disorders Later, this fund of knowledge was applied by Sullivan and others to the study of environmental and social factors. Careful study of psychopathologic symptoms and syndromes produced especially fruitful results in French and German psychiatry. Although the influence of these developments on psychotherapy was marked, little actual research work was done in this field. From time to time clinical studies appeared which gave valuable information, e.g., with regard to the late-life period and early senescence, and in clarifying various types of depressive and paranoid illnesses. Senile and schizophrenic psychopathology became better understood.

With the introduction of experimental psychologic studies by Kraepelin, many valuable experiments were carried out by psychologists and psychiatrists. They have clarified thinking disorders in connection with strong emotions, confusional episodes, and brain damage. In this latter field, Pavlov's concepts have been especially valuable. In the United States, investigators tried to apply knowledge gained from animal studies. One of the outstanding European contributions was the Rorschach experiment which can still offer important data in many aspects of psychopathology. In more recent years, together with a similar development in research in the broad field of medicine, physiologic and pharmacologic investigations have shown promise, often in collaboration with psychologic investigators. In the field of therapy, the greatest research contribution was undoubtedly made by Wagner von Jauregg which led to fever therapy in general paresis.

Research in psychiatry has expanded and the future looks promising if we clinicians, teachers and investigators can grow with the development of medicine and science in general and adapt our thinking and the pursuit of goals and methods to changing conditions.

Résumé

La recherche en psychiatrie doit appliquer les mêmes principes généraux que la recherche dans n'importe quel autre secteur scientifique. Les maladies mentales ne correspondent pas encore à des entités bien définies car l'évaluation diagnostique dépend en grande partie des

conceptions théoriques de l'observateur; en bref, les maladies mentales demeurent encore imparfaitement classées. Il faut retenir qu'elles ont toutes une composante psychologique, physiologique et socio-culturelle. Il semble établi que toute recherche psychiatrique doit être basée sur une approche psychopathologique dynamique, qu'il s'agisse d'observer des manifestations évidentes ou latentes. Une description soignée de l'observation est essentielle, que la recherche s'oriente vers la psychologie ou la physiologie pathologiques. Il est indispensable de dresser un graphique du comportement. Une attention particulière sera apportée aux manifestations de *ressentiment* dont on connait si mal les modalités d'élaboration et d'apparition. On utilisera le malade lui-même comme "contrôle" car les "contrôles" étrangers soi-disant sains sont parfois décevants. L'expérimentation chez l'animal demeure encore fallacieuse surtout lorsque les réactions émotionnelles impliquent un contexte idéique. L'anxiété n'est peut-être pas l'émotion fondamentale; est-elle la même chez le névrosé et chez le schizophrène? La recherche dans le sens pavlovien est trop limitée pour permettre de conclure. Il demeure acquis que la recherche en psychiatrie est liée aux progrès de la biologié, de la médecine, de la philosophie et des influences culturelles.

La contribution pharmacologique est en pleine effervescence et elle demeurera prometteuse à condition de l'appliquer à l'avancement de la connaissance. La génétique et l'approche socio-culturelle font partie de la recherche dans les cadres globaux de celle-ci, la psychopathologie et l'étude de la personnalité dominant les investigations de base.

L'étude des dysendocrinies a déjà apporté d'intéressantes contributions. Les corrélations de la chimie et de la psychologie ne vaudront que dans la mesure où elles seront confrontées soigneusement avec les données psychopathologiques.

En bref, il est évident que les recherches psychodynamiques, physiologiques et expérimentales seront les plus fructueuses si elles sont conduites dans les centres d'enseignement bien pourvus de laboratoires et de travailleurs intéressés à la recherche dans les disciplines connexes. Un département de psychologie expérimentale et de recherches physio-pharmacologiques est indispensable; enfin, une section d'histoire de la psychiatrie devient un adjuvant utile. Mais, malgré tout cet arsenal l'étude et le traitement de chaque malade doivent toujours commencer par l'investigation de la psychopathologie dynamique.

DISCUSSION I

HENRI ELLENBERGER, M.D.
Montreal

It is a great honour for me to participate in the discussion of Dr. Oskar Diethelm's paper. First of all, I want to congratulate him on his splendid presentation in which the best traditions of European psychiatry were combined with the most progressive North American approaches.

Dr. Diethelm has given us an account of the present state and problems of psychiatric research, a careful and critical evaluation of what has been accomplished in that field and of how the effort should be pursued.

Listening to Dr. Diethelm's paper, it was comforting to hear of some remarkable achievements of modern psychiatry, but also impressive to realize how much, in the field of psychiatric research, is still fraught with incertitude and error.

An experimental psychiatrist, Dr. Diethelm reminded us, must not only master the principles and techniques of scientific investigation in general and of medical

research at large, he must also master those specific principles and techniques proper to psychiatric research.

The object of psychiatric inquiry, i.e. mental disturbances, is certainly not an easy one. Our diagnostic categories are uncertain. In any given case of a mental condition, physiological, psychological and cultural components are intermingled. We perceive the overt aspect of mental disorders, while what goes on underneath eludes our investigation to a large extent. The charting of human behaviour depends much on a personal equation of the observer. No valid conclusion can be drawn without a prolonged period of observation, which often exceeds the limitations of the usual research work. Dr. Diethelm also reminded us that the use of controls in psychiatric research is liable to error. In regard to psychopathological experimentation on animals, which seems to be the *non plus ultra* of certain schools, we should not forget its limitations, either. Dr. Diethelm suggested that animal experimentation will perhaps help us to understand certain problems of genetics or of infancy, but how can we reproduce in animals such an exquisitely human feeling as resentment? Another recent trend, psychopharmacology, has enlarged our means of experimental approach but also given rise to such fallacies as the equating of peculiar transient visual hallucinations with schizophrenia. In the fields of psychiatric genetics, social psychiatry, cultural psychiatry, psychoanalysis, there are many other difficulties to which Dr. Diethelm pointed out with the diagnostic acumen of an expert clinician. On hearing his paper, I could not help remembering the old aphorism of Hippocrates: *Art is long, life is short, opportunity fleeting, experience deceptive,* and also—to come to more recent times—the wonderful little book of Eugen Bleuler, *Autistic-Undisciplined Thinking in Medicine.*

Dr. Diethelm emphasized that however important and vital psychiatric research may be, it should not deter us from cultivating the good old, traditional, clinical psychiatry. I am afraid that he here touched on a topic which, to several of us, is a neuralgic point. Present-day psychiatrists have been so much concerned with physiopathology and with dynamic psychopathology, i.e. with the various "backgrounds" of mental conditions, that there has been a risk of overlooking the more immediate aspect of these conditions, that is, the clinical pictures themselves, with their signs and symptoms, their semeiology, their differential diagnosis. In our psychiatric schools, many young and post-graduate students are so eager to interpret a clinical case "dynamically" that they do not bother about what they consider "superficial" symptoms, and even less about the so-called "label" fitting into "official" nosological classification! Such young people would be able to give a brilliant interpretation of a patient's libidinal vicissitudes and ego defenses, but unable, at an examination, to furnish a clear description of hebephrenia for instance, and explain in what way this condition differs, say, from simple schizophrenia. Perhaps the philosopher was right who said that "progress does not consist only in making new acquisitions, but also in not forgetting the acquisitions of the past".

Among the many other stimulating issues raised by Dr. Diethelm, let me recall one more: promising psychological experiments, he said, are often developed prematurely into tests which may have a diagnostic or therapeutic relevance but contribute little to the augmentation of psychiatric knowledge. Apparently we have here one manifestation of the widespread antagonism between the desiderata of "basic research" and the needs of "applied science".

To this general dilemma must be added another one, particular to psychiatry: The contrast between the perspectives of the psychotherapist and of the experimental psychiatrist. Two conceptions of the psychic reality seem to be facing each other. One is the powerful modern

trend toward experimentation, quantification, measurement, not only in physics, but in the total realm of the human soul. In that perspective, dynamic psychiatry is no doubt liable to criticism. Who has ever been able to measure libido, ego strength, superego, and the like? The very existence of these entities has never been demonstrated. The opposite viewpoint is often represented by those psychotherapists who devote themselves exclusively to dealing with their patients in the immediate situation of the therapeutic interview; to them these terms are not abstract conceptualizations, they are living realities whose existence is much more tangible than the statistics and computations of the experimental researcher. C. G. Jung declared once: "Whosoever wants to know about the human soul will learn nothing, or almost nothing, from experimental psychology". The successive apparition of Freudian psychoanalysis, of Jungian psychology, of existential analysis, might be considered as a natural counterpart to the growing emphasis put by the experimentalists on the various "reductions" of human psychic life. Be that as it may, it would seem that the realm of psychic life can be approached from two sides, the one as legitimate as the other: either with the immediate, non-quantifiable approach of the psychotherapist,—or with the accurate techniques of measurement, quantification and experimentation of the research specialist.

This brings us to the problem of psychiatric progress. How important psychiatric research is to the progress of our science, how rewarding the findings, is obvious to anyone who is acquainted with the work of certain hospitals or institutes—among which I would ask permission to mention the Payne Whitney Psychiatric Clinic. For the sake of Public Health and the future of science, it must be hoped that research work of such quality will be developed for a long time to come.

It would be fine, indeed, if science could progress automatically by means of a large number of elaborate well-planned research projects, with clearly stated hypotheses, nicely devised experiments, and a rigorous methodology. Unfortunately the motto "Seek, and ye shall find!" does not always come true. Sometimes one would almost be reminded of what Faust said of his zealous disciple Wagner:

> "He starts digging eagerly in search
> for a hidden treasure,
> He finds a little worm—and lo, he
> swells with pleasure"

But whether we are rewarded for our toil by finding a little worm or a big treasure, the idea is the same: we assume that the progress of psychiatry eventually depends on the progress of research. Is this always true? This question is perhaps not unworthy of some attention.

When Kraepelin in 1920 founded the first Psychiatric Research Institute, the *Forschungsanstalt* of Münich, psychiatry was already a very old science and it had not waited until that date before progressing. This is clear, if we compare the state of psychiatry at various points of its history. It would be easy to show how the progress of psychiatry, from Galen to Zacchias, from Zacchias to Esquirol, from Esquirol to Morel, from Morel to Kraepelin, depended on the general cultural trends: Renaissance humanism, philosophy of Enlightenment, and on the progress of the various sciences.

I would now like to present for your consideration an idea which may strike you as unsound, unscientific, and even heretical. It seems to me that there are two main sources that are endlessly rewarding for a research-minded psychiatrist.

The first is when a psychiatrist must deal with his own neurosis. Thus, he may describe it at length, as Robert Burton did in his famous *Anatomy of Melancholy*, (1628), or he may take it as a prototype for a supposedly new condi-

tion, as did George Cheynes in his monograph *The English Malady*, (1773), a book in which he gave a description of hypochondriasis which was classical for two centuries. Not very different was the story of Morel who in 1866 published a famous description of what he called the *délire émotif*, a condition known today under the name of phobia. One of the case histories was that of Morel himself, who had carefully recorded his symptoms over a period of 4 or 5 years.

Sometimes a psychiatrist will not publish his auto-observation under that direct form, but rather take it as a frame of reference for investigations performed in other patients, and as the starting-point for new theories. Thus, although we do not know very much about the long period of neurotic breakdown that Pierre Janet endured in his youth, we know enough to identify it with much of what he later described under the name of "psychasthenia." In regard to Freud, all those who have read his illuminating biography by Ernest Jones know that he for several years suffered from a severe "neurasthenia" which he was able to overcome through his heroic efforts at self-analaysis. Thus doing, he discovered new techniques, a method of interpretation of dreams, the Oedipus complex, and many other basic principles of psychoanalysis. Pavlov himself, it has been alleged, shifted to psychiatry after he in 1927 underwent an operation for gallstones, followed by a heart neurosis, which he described in a paper: *A post-operative cardiac neurosis partially analysed by the physiologist-patient I.P.P.* Is it not strange, indeed, to think that the two greatest psychiatric systems of our time would perhaps never have been created without the neurosis of their discoverers?

The second, perhaps even richer source for creative psychiatric research, is when a psychiatrist is involved in a long-standing, almost interminable analysis with a hysterical woman and genuine scientific interest, transference and counter-transference are almost hopelessly mixed. To give examples would amount to retracing the whole history of dynamic psychiatry, beginning with its ancestor Franz Anton Mesmer. The discovery of "animal magnetism" is connected with Mesmer's treatment of a hysterical young woman, Fräulein Oesterlin. While trying to treat her, Mesmer discovered the curative virtue of "animal magnetism". The following year Mesmer undertook the cure of another young woman, the blind musician Maria-Theresia Paradis. The long story of the treatment, intermingled with a transference–counter-transference relationship, is well-known: its outcome was Mesmer's departure from Vienna and his founding a new school in France. The whole history of Dynamic Psychiatry issued from that momentous event.

Another pioneer of dynamic psychiatry, Justinus Kerner, made himself famous by his study of a hysterical woman, Friedericke Hauffe, whom he studied for several years and about whom he published a book, *The Seeress of Prevorst*, the first monograph devoted to one mental patient. This book is still valuable as the record of an involuntary experiment of the mythopoetic functions of the unconscious, when given time and favorable circumstances. The same could be said about Charcot's famous patient, Blanche Wittmann, who served as the prototype for Charcot's description of hysteria and his experiments on artificial somnambulism.

Pierre Janet told in an autobiographical notice that he shifted from philosophy to psychopathology after he became so much interested in another hysterical woman patient, Léonie. He investigated this patient for several years and took her case as a basis for the theories compiled in his famous book, *L'Automatisme Psychologique*. After him, Théodore Flournoy also devoted several years to research on a hysterical medium, Helene Smith. He showed how her reincarnations were "romances of the subliminal imagination", bringing forth forgotten childhood

memories under the effect of emotional regression and wish-fulfilment. He only overlooked the fact that the patient was acting out these performances because of her transference and of his own unconscious counter-transference. It was reserved for Freud to discover these two manifestations.

The readers of Jones' biography of Freud remember the extraordinary story of the hysterical girl, "Anna O." with whom Breuer was involved in a long and at times ambiguous relationship of hypnotizer to patient. This woman, who later made such a remarkable career, provided Breuer with the concept of cathartic treatment and Freud with the concept of transference. It is not an exaggeration to say that she played a fundamental role in the origin of psychoanalysis.

One is also reminded of the young hysterical girl whom C. G. Jung analyzed with so much detail and described in his dissertation *On the Psychopathology of So-Called Occult Processes* – a book which contains the germs of Jung's later concepts, notably that of individuation.

In short, one could say that the history of psychiatry, especially of dynamic psychiatry, is associated with the history of a group of remarkable, hysterical female patients, whose contribution to the progress of our science has been unjustly neglected.*

These cases of the psychiatrist's own neurosis, and of his involvement with a hysterical patient, may be considered as special instances of a more general situation: that is, of the psychiatrist facing a new and unknown problem for which he has no immediate answer and for which he is forced to discover a new solution. Other examples would be those of the psychotherapist dealing with a severely schizophrenic patient, with a reluctant and unwilling patient in a prison setting, or in any other "unorthodox" situation, which has not been foreseen by the textbooks. A friend of mine, who was working with criminals, told me that sometimes he could not help comparing his own situation to that of Koehler's ape, Sultan. This famous animal had to reach some bananas which were hanging too high up and he had to discover a new trick–which he did. My friend sometimes wishes that he could have been so successful. Who knows if, after all, the experimentation with animals will not help us, not only to clarify problems of mental disturbances, but also to shed light on certain new aspects of psychiatric progress?

Perhaps the time is coming when, as in other disciplines, we will have to build a science of psychiatric research. This science will owe a great deal to reports such as that of Dr. Diethelm, whom I would like to thank once more and to congratulate.

*The discussant's viewpoints have later been expounded in a paper, "La Psychiatrie et son histoire inconnue", *L'Union Médicale du Canada*, vol. 90, pp. 281-289, March, 1961.

DISCUSSION II

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La réputation du Professeur Oskar Diethelm, ses origines suisses au carrefour des civilisations européennes, un long commerce avec son maître Adolph Meyer, son expérience à la direction d'une clinique psychiatrique réputée des Etats-Unis nous laissaient présumer un exposé de qualité. Notre espoir n'a pas été déçu. La vision panoramique brossée par le Professeur Diethelm s'avère des plus réconfortante. Nous y retrouvons la sérénité et l'humanisme qui caractérisent si bien son enseignement. Esprit ouvert à toutes les disciplines, le Professeur Diethelm les scrute à tour de rôle et trouve à chacune sa place en recherche psychiatrique. Nous ne sentons chez lui aucune passion doctrinale susceptible de fausser l'optique de sa vision d'ensemble. Psychiatre, il ne renie pas sa médecine et il sait

lui assigner son rôle en pathologie mentale. Médecin imbu de concepts physiologiques, il souligne néanmoins l'importance primordiale des données dynamiques en psychiatrie. Clinicien dans l'âme, il reconnaît cependant la juste influence des facteurs sociaux et culturels dans la genèse des troubles psychiques. Enfin, homme de science, il accepte sans humeur chagrine les limitations de la méthode expérimentale appliquée à la psychiatrie.

Nous sentons toutefois chez lui un attachement particulier à la psychiatrie clinique. Cette affection le rapproche davantage des psychiatres cliniciens que nous sommes tous pour la plupart. Son exemple nous rassure dans notre poursuite de la vérité quand il semble réaffirmer avec les grands maîtres des écoles européennes que la Voie Royale de la psychiatrie demeure toujours orientée dans le sens de la recherche en psychopathologie. Nous aurions apprécié cependant qu'il formulât plus longuement sa pensée sur ce sujet et nous aurions aimé l'entendre développer davantage son approche méthodologique du double aspect du phénomène psychopathologique.

Dans ses remarques préliminaires, le Professeur Diethelm énonce les principes qui définissent la psychiatrie une science distincte dont l'objet propre échappe aux règles habituelles de la recherche scientifique. Plus tard, il surprend parmi nous les tenants stricts d'une science objective et risque de scandaliser nos cousins psychologues en refusant à l'expérimentation et à l'épreuve de laboratoire le monopole exclusif de la vérité psychiatrique. Nous aurions aimé à ce moment l'entendre disserter plus à fond sur les critères de validation de la méthode clinico-pathologique qu'il nous propose.

Si la perspective envisagée par le Professeur Diethelm nous apparaît optimiste, elle ne va pas jusqu'à l'extrême de certains collègues qui voient en ce siècle l'âge d'or de la Psychiatrie. Cependant, on pourrait reprocher au Professeur Diethelm de ne pas tempérer son optimisme serein par la définition des facteurs négatifs susceptibles de vicier ou de freiner les progrès de la recherche psychiatrique.

Sans doute, les attaches originelles du Professeur Diethelm à une république réputée pour sa neutralité le retiennent-elles de stigmatiser les discordes stériles d'écoles incrustées dans leur orthodoxie pour qui la recherche est davantage un moyen de justification qu'une quête de vérité. Sans doute sa perspective objective n'a pas permis au Professeur Diethelm de se pencher sur la personnalité du chercheur et de son influence sur la recherche. En effet, l'interaction dynamique constante du sujet et de l'objet assume une si grande place en psychiatrie que la personnalité de l'observateur et ses motivations risquent souvent de fausser les résultats. L'abondance de déchets dans la littérature psychiatrique explicable en partie par un narcissisme académique obéissant au diktat "publish or perish" témoigne de l'importance de ce facteur. De la même manière, le chercheur guidé par son angoisse, sa ruse, son sexe, sa religion, ses limites de connaissance peut poursuivre dans sa démarche scientifique davantage une sécurité, une foi, qu'une vérité. L'oubli habituel des travaux connexes publiés en langue étrangère dans la littérature psychiatrique anglo-saxonne et russe, tout en suggérant un racisme scientifique de mauvais aloi, semble confirmer cette assertion.

Enfin, mentionnons les pervers de la recherche qui déplacent leur libido sur la perfection de leur instrument de travail au détriment de l'objet même de leur recherche.

En contrepartie, le Professeur Diethelm aurait sans doute pu à la lumière de ses vastes connaissances historiques souligner précisément les défauts de personnalité, les traits névrotiques, qui dans le passé ont favorisé certaines découvertes et qui dans l'avenir pourraient encore jouer un rôle contributif.

Si le Professeur Diethelm n'a fait qu'effleurer ces aspects négatifs de la recherche psychiatrique, sans doute a-t-il

été retenu par son expérience de pédagogue conscient des dangers du mauvais exemple.

En dépit de ces réserves minimes, les considérations du Professeur Diethelm demeurent un tout cohérent assignant à chaque partie son rôle précis dans l'élaboration de la pensée psychiatrique. Pareil point de vue tient sans doute à sa conception Meyerienne de la psychiatrie. Mais quand le Professeur Diethelm ose affirmer en Amérique du Nord que la pensée philosophique participe à l'avancement de la psychiatrie aux mèmes titres que la biologie, la médecine, et la sociologie, ça n'est plus un psychiatre, mais un humaniste qui parle, un humaniste bien près de la pensée de Claude Bernard: "Je suis persuadé qu'un jour viendra où le physiologiste, le poête et le philosophe parleront la même langue et s'entendront tous". Dans l'attente de ce jour Edénique, il est consolant de constater que le Professeur Diethelm a fait beaucoup pour que les psychiatres parlent la même langue.

PSYCHOTHERAPIES ET PSYCHANALYSE*

J. B. Boulanger, M.D.[1]

Pour le praticien d'aujourd'hui, la psychiatrie n'évoque plus automatiquement l'asile avec les formules d'internement ou les assises avec l'expertise médico-légale, et la psychanalyse, un réflexe nauséeux ou un sourire de mépris.

Il cherche à s'instruire, à comprendre. Il y est forcé par ses malades qui réclament quotidiennement sédatifs, tranquillisants, somnifères, par les échecs répétés des thérapeutiques destinées aux troubles dits fonctionnels, par l'expérience psychologique que lui apporte la fréquentation intime de la souffrance humaine.

Est-ce à dire qu'il doive se démettre, de sorte que le psychiatre deviendrait, à toute fin pratique, l'omnipraticien de notre temps? Dans quelle mesure peut-il se substituer avantageusement au psychiatre? Certaines formes de psychothérapie paraissent relever de sa compétence, le recours au spécialiste étant prévu pour les situations qui exigent une formation théorique et une préparation technique plus poussées

Le névrosé est un malade. C'est une évidence reconnue par le chiropraticien et le guérisseur, mais souvent niée de fait par le médecin.

La distinction entre l'organique et le fonctionnel est spécieuse et arbitraire, quand on sait que la lésion d'un organe se traduit par une fonction altérée et qu'une dysfonction prolongée détermine des atteintes organiques. Un traitement rationnel et efficace ne semble guère possible, dans les cas "psychosomatiques," si la responsabilité est partagée entre celui qui soigne le corps et celui qui soigne l'esprit.

Dans la plupart des cas, l'anamnèse et l'examen du malade permettent au médecin de poser un diagnostic et d'instituer ou de recommander un traitement. Pourquoi cette subite ignorance et cette crainte extrême qui le font se récuser dès qu'il soupçonne un problème psychiatrique? Il a oublié que les premiers médecins, ceux qui fondèrent sa profession, étaient des "médecins de l'âme", littéralement des psychiatres.

On peut invoquer une méfiance à l'égard de méthodes qui lui sembleraient peu scientifiques et dont il abandonnerait l'usage à certains demi-confrères. Cette attitude est dépassée. On peut aussi blâmer les études médicales, qui détourneraient d'une compréhension intégrale de la santé et de la maladie chez l'homme. Les programmes d'enseignement à la Faculté et dans les hôpitaux se sont transformés depuis plusieurs années afin de préparer le futur docteur à une approche moins compartimentée et plus dynamique de l'être humain dans sa totalité.

Il n'y a pas que monsieur Jourdain à faire de la prose sans le savoir. Le médecin ou le chirurgien qui remonte le moral du patient, qui le calme et le réconforte, témoigne implicitement, à son insu parfois, d'une profonde connaissance des mécanismes psychologiques et de l'art de les utiliser. C'est le prototype de la psychothérapie de soutien.

Les mesures diététiques et hygiéniques, les médications non spécifiques, le repos et les voyages imposés s'inspirent des mêmes principes que les psychothérapies directives. On ne saurait éliminer la suggestion des facteurs qui provoquent des réactions si variables dans l'emploi de médicaments physiologiquement actifs.

Même si elles n'osent dire leur nom, on doit reconnaître la vraie nature de ces psychothérapies et la véritable portée des actes que pose "le psychiatre malgré lui."

Communication à la Société canadienne de psychanalyse, sous les auspices du XXIX Congrès de l'Association des médecins de langue française du Canada, Montréal, le 23 septembre 1959.

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Leurs résultats dépendent de la confiance que le malade place en son médecin, de l'action, voulue ou non, de ce que la psychologie désigne par le terme de transfert positif. L'omnipraticien ou le psychothérapeute qualifié est transfiguré en père bénéfique et tout-puissant, qui procure santé et bonheur. Dans ce siècle de la pensée scientifique, le médecin a hérité de la fonction magique de son ancêtre, le sorcier. Le psychiatre détient le pouvoir de guérir les âmes et d'en chasser ses démons intérieurs.

Cette spécialisation, issue d'une fallacieuse dichotomie, n'est justifiée que dans les cas qui requièrent l'emploi de techniques inaccessibles à ceux qui ne les ont pas apprises. Le choix du thérapeute est déterminé par la nature de la maladie et du traitement envisagé ou exigé dans la circonstance.

En premier lieu, un diagnostic psychiatrique ne s'établit pas par élimination. Une observation complète comprend un examen psychologique. Quand on a posé un diagnostic d'ordre psychiatrique qui rend compte de la symptomatologie, il n'y a pas lieu de procéder à des examens coûteux en temps et en argent, qui sont inutiles et préjudiciables, car on risque de fixer irrévocablement le malade sur les fausses pistes qu'il ne demande qu'à suivre.

Tout comme il songerait à obtenir l'avis d'un spécialiste sur une masse palpée au cours d'un examen gynécologique, le médecin agirait dans l'intérêt du malade en demandant une consultation psychiatrique si le cas présente des difficultés qui dépassent sa compétence.

Ainsi, il n'est pas toujours facile pour le profane de distinguer d'emblée une réaction anxieuse d'une phobie ou d'une obsession. L'enfance, l'adolescence et le climatère ont une psychologie qui leur est propre et qu'il ne faut pas confondre avec des troubles au pronostic réservé.

Parents et maîtres sont trop enclins à s'inquiéter si un enfant ne se conforme pas d'assez près aux critères de normalité qu'ils ont érigés; ils ont alors besoin d'être rassurés et conseillés. Mais un psychiatre de l'enfance découvrira peut-être, dans le comportement impulsif d'un autre enfant, les prodromes d'une délinquance ou d'une psychose qu'il s'agit d'enrayer par un traitement d'urgence. La ligne de démarcation est souvent confuse, chez l'adolescent, entre le retrait progressif de la schizophrénie et la crise d'isolement soupçonneux qui caractérise cet âge. Au climatère, une mélancolie d'involution avec danger imminent de suicide peut, à son début, être méprise pour un épisode banal de dépression réactionnelle.

On comprend la nécessité, dans ces cas complexes, d'un examen psychiatrique minutieux et approfondi. Il n'est pas rare, dans mon expérience, que le malade soit par la suite traité par son médecin, qui au besoin demandera conseil auprès du psychiatre consultant. C'est le choix le plus heureux, et il s'impose quand le spécialiste ne peut offrir davantage que l'interniste ou l'omnipraticien doué.

Il serait imprudent pour un autre qu'un homme du métier de traiter une psychose aiguë ou d'utiliser des thérapeutiques peu familières, telles que l'électrochoc, le coma insulinique, l'hypnose et la narcose. A moins d'une préparation adéquate, que l'on soit médecin ou psychiatre, il vaut mieux ne pas psychanalyser en amateur tous ceux qui présentent des complexes.

On a proposé tellement de définitions de la psychothérapie, des professions si variées et de si nombreuses écoles, malgré leurs divergences conceptuelles, s'en réclament, qu'il serait pour le moins singulier que le médecin, dont la formation et la vie sont centrées sur le traitement des malades, fût le seul à se voir refuser le droit de l'exercer.

Nous avons déjà dégagé la part importante de psychothérapie qui s'insère dans l'acte médical le plus courant. La psychothérapie se définirait comme l'action thérapeutique de l'esprit sur l'organisme malade. Plus ou moins systématiques et structurées, diversement appliquées et orientées, toutes les psychothérapies visent à la suppression des symp-

tômes perturbateurs et à une meilleure adaptation sociale de la personnalité.

L'issue favorable d'un tel traitement présuppose un accord tacite entre le malade et le thérapeute sur les valeurs menacées par la maladie et que rétablira l'influence normative de la psychothérapie. Il s'agit bien d'une rééducation.

Le psychothérapeute a le choix de plusieurs techniques:

1° la suggestion, l'orientation, les moyens rassurants, qui permettent à un moi faible ou à un moi submergé par un *stress* trop intense de se reconstituer en empruntant sa force au thérapeute;

2° l'abréaction ou *catharsis*, qui dégage la tension accumulée des expériences traumatiques et prévient l'installation durable de défenses névrotiques;

3° l'intervention active dans la vie et le milieu du malade, afin de corriger des attitudes indésirables ou d'en promouvoir de plus souhaitables;

4° l'exploration ou la mise au point des motivations et des émotions du malade, qui peut ainsi les mieux contrôler.

Ces méthodes ont leur indication première dans les états anxieux et réactionnels qui ne sont point encore organisés et structurés en psychonévroses. On les utilise dans les dépressions, chaque fois qu'un conflit extérieur est en cause. L'abréaction produit des résultats parfois spectaculaires dans les névroses traumatiques. L'intervention active et les procédés explicatifs constituent les approches les moins dangereuses et souvent les plus efficaces dans les maladies psychosomatiques. Avec les adolescents, les techniques d'exploration, les attitudes non-directives sont les plus utiles.

Le malade, dans ces modalités de psychothérapie, n'est pas requis de communiquer tout ce qui lui vient à l'esprit et d'abandonner tout contrôle de ses pensées et de ses fantasmes. On le ramène aux situations actuelles et on examine ses relations interpersonnelles. De nouvelles solutions, des attitudes modifiées apparaissent au cours de cette constante confrontation avec les exigences de la réalité. Le thérapeute maintient et favorise un rapport positif, sans en dévoiler les mécanismes secrets.

L'expérience démontre que les résultats de ces psychothérapies ne dépendent pas directement de la formation théorique ou technique du thérapeute. Ses capacités se mesurent à sa tolérance de l'angoisse que provoquent en lui les conflits de son malade.

La psychanalyse ne se se distingue pas essentiellement de la psychothérapie par des caractères tels que la position couchée du malade, le rythme des séances, la longueur totale du traitement ou le refus de prescrire des médicaments.

La fréquence peut varier, selon les cas et l'évolution du traitement, entre une séance par jour et une par semaine, aussi bien en psychanalyse qu'en psychothérapie. Certains psychiatres non analystes se servent toujours du divan, et il n'est pas interdit au malade de s'asseoir au cours d'une séance d'analyse. Des psychothérapies qui s'intitulent brèves peuvent s'étendre sur des années, alors que des analyses ont pris moins d'un an. On traite de plus en plus fréquemment des prépsychotiques et des psychotiques par l'analyse classique associée aux neuroleptiques et thymoleptiques. On est en droit de se demander s'il y a des analyses où il n'entre, sous forme de soutien et de clarification, peu ou prou de psychothérapie.

Les critères de l'interprétation psychanalytique, comparée à l'intervention psychothérapeutique, se ramènent à trois aspects:

1° l'interprétation fait ressortir la signification inconsciente des associations libres du malade, la relie aux fonctions défensives du psychisme et la ramène à ses sources infantiles;

2° on interprète de façon systématique les réactions transférentielles;

3° le symptôme est traité comme un produit dérivé d'un conflit intérieur, que le malade doit résoudre, une fois libéré des entraves de son passé.

La psychanalyse est donc indiquée chaque fois qu'est recherchée une modi-

fication structurale de l'univers psychique du malade, pour l'autonomie et l'épanouissement de sa personalité. Elle est spécialement destinée au traitement des névroses fortement structurées, comme les état obsessionnels et phobiques, les troubles graves du caractère, aux cas où le conflt est intériorisé et où le malade est motivé par une souffrance psychique telle qu'il préfère aux illusions et à la dépendance de la névrose, les désenchantements de la vérité et les obligations de responsabilités librement consenties.

Les résultats de la cure psychothérapeutique ou psychanalytique sont comparables à ceux qu'on observe dans la thérapeutique générale de l'art de guérir. Autant il serait déraisonnable de chercher en psychiatrie une panacée, autant il est injustifié d'exiger d'elle des miracles. Elle ne mérite "ni cet excès d'honneur ni cette indignité." Ce pessimisme comme cet optimisme exagérés découlent en fait d'une même conception mystique ou magique, qui doit demeurer étrangère à la pensée scientifique.

Quelles sont les maladies qu'on guérit au sens strict? Prenons celles de l'appareil respiratoire. On guérit cliniquement et anatomiquement, et même là pas toujours, une pneumonie lobaire franche aiguë. Les derniers traitements de la tuberculose pulmonaire, qui ont fermé les portes du sanatorium de Saranac, seront-ils inscrits comme des échecs, parce que la guérison n'est pas aussi parfaite que dans la pneumonie? Les moribonds que l'on rendait naguère à une vie active et utile par les cures classiques n'étaient jamais guéris. En psychiatrie, certains états confusionnels aigus sont peut-être les seuls cas qui soient vraiment curables, et encore sous réserve.

Cette distinction fondamentale entre les maladies aiguës et les maladies chroniques est familière à tout médecin. La psychothérapie et la psychanalyse s'adressent par définition à des malades chroniques, dont les critères de guérison sont identiques à ceux que la tradition médicale et les sens commun a reconnus dans ce genre d'affections. La chirurgie se prétend éminemment curative. Et c'est à l'un de ses maîtres que nous devons ce rappel de sage modération sur les limites humaines de toute thérapeutique: "Je le pansai, Dieu le guérit."

Summary

With the medical profession's growing awareness of the patient as a psychobiological entity, psychiatric assessment and treatment have become so prevalent that the physician is expected to appreciate the emotional aspects of illness and often required to include psychotherapy in his office or bedside routine. Some cases would be more effectively handled by him than by the psychiatrist; others demand special skills and should be referred to a colleague with the requisite training.

Many misunderstandings and disappointments could be avoided if the medical practitioner had a clearer view of the specific indications and methods, scope and limits of psychiatric care. In this paper, discussion is restricted to psychotherapy and an attempt is made to differentiate between its various types and applications; special attention is given to psychoanalysis.

The common characteristics and basic postulates of psychotherapeutic techniques are examined. Their choice is determined by the relative importance of actual situations and internal conflicts, the dynamic structure of the psychological disorder and the objective of symptomatic relief or personality change.

The mechanism of the cure, particularly the transference reactions, are compared. Adjustment to reality and reeducation of the patient are opposed to his confrontation with his unconscious world.

Paper read in English ('Psychotherapy and Psychoanalysis') at the 28th Annual Meeting of the Royal College of Physicians and Surgeons of Canada (Division of Medicine), Vancouver, 24th January, 1959.

L'ASPECT CHANGEANT DE LA SCHIZOPHRÉNIE*

ROGER R. LEMIEUX, M.D.[1]

Le phénomène n'est pas nouveau en médecine qu'une maladie qui nous semblait complexe et irréversible — par exemple, le diabète ou la syphilis — ait avec le temps, une meilleure connaissance de sa pathologie et de sa thérapeutique, changé d'aspect et se soit en apparence simplifiée.

Il y avait déjà une longue évolution de nos idées qui se traduisait dans le remplacement du terme "démence précoce" par "schizophrénie". Ce sont les études psychopathologiques, dynamiques des dernières années qui ont modifié encore une fois l'appellation diagnostique. On emploie de plus en plus le terme "réaction schizophrénique" qui semble impliquer que cet état peut être provisoire.

Est-ce de notre part l'effet d'une pensée magique sans fondement qui nous fait voir les choses ainsi?

Si nous avons l'impression que la schizophrénie se traite plus facilement, à quoi le devons-nous? A des méthodes de traitement plus affinées et plus diversifiées sans doute, mais aussi, semble-t-il, au fait que la maladie elle-même semble changer; cette constatation, à première vue étrange, est enregistrée par Arietti dans l'American Handbook of Psychiatry. Si cela se vérifie, ce serait un fait troublant pour celui qui est accoutumé à penser en termes d'entités cliniques. D'autre part, ce serait un argument très fort entre les mains de ceux qui considèrent la schizophrénie comme une réaction à un stress. Et si les symptômes en sont plus bénins, cela nous conduirait à nous demander quelle influence, interne ou externe, serait moins stressante. Mais d'abord est-il bien vrai que la symptomatologie ait changé?

Dans mon expérience clinique, j'ai l'impression que les schizophrènes qui sont vus pour la première fois par le psychiatre sont moins malades qu'ils l'étaient. Leurs symptômes sont *moins* dramatiques, leur anxiété est *plus* grande, ils cherchent secours. Les formations secondaires sont moindres, l'indifférence, l'émoussement de l'affect presque inexistant. Il se peut que nous les voyions plus tôt parce que le public est plus conscient de ce qu'est la maladie mentale et de ce que la psychiatrie peut apporter dans le soin de ces malades.

D'autres faits cependant sont plus difficiles à expliquer: ainsi la fréquence relative des divers types de schizophrénie a changé; on rencontre plus rarement l'hébéphrénie: cependant, si celle-ci représente une désintégration d'un processus paranoïde, on peut croire qu'elle est moins fréquente parce que le malade est vu plus tôt, avant qu'une détérioration dans ce sens se produise.

Comment expliquer la rareté des formes catatoniques? Il est maintenant presque impossible de présenter aux étudiants en médecine un malade qui en a les symptômes! La stupeur catatonique est inexistante. Et pourtant c'était, il n'y a pas si longtemps, une forme aiguë et dramatique d'apparition de la schizophrénie. L'agitation catatonique est-elle plus fréquente? Bien que nous employions rarement ce diagnostic, nous y pensons encore souvent en face d'un jeune malade mais nous en venons éventuellement à un diagnostic de type schizo-affectif: cela n'a rien qui doive nous surprendre en milieu canadien-français où la manie est beaucoup plus fréquente chez de jeunes adultes qu'elle l'est dans les milieux anglo-saxons ou américains.

La forme paranoïde est de toutes la plus fréquente mais là encore il y a atténuation des symptômes: les idées dé-

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lirantes sont moins nombreuses (au moins exprimées – ce qui reviendrait au même puisque ce serait un signe de croyance incomplète), les hallucinations moins fréquentes, l'aggression rare, l'hostilité est vécue plus comme une vague méfiance de l'entourage.

Du point de vue thérapeutique, nous pouvons nous réjouir que le type paranoïde soit plus fréquent puisque c'est celui où la détérioration est la moins manifeste. Ceux qui en souffrent seront plus susceptibles de traitement quoique le début de la psychothérapie sera plus difficile à cause de leur suspicion. Leur soin est d'ailleurs difficile en hôpital ouvert parce qu'ils ont un ego assez cohésif pour nier être malade et refuser la situation thérapeutique en maintenant une façade souriante, vernissée, conformiste aussi longtemps que possible. Certains de ces malades ont refusé la relation thérapeutique pour plus de deux mois et ont dû finalement être transférés en milieu fermé ou encore, retournés à leur milieu, ils y ont continué une existence en bordure de la vie de leur entourage. Quelquefois, ils sont revenus après un temps au traitement qu'ils avaient refusé, rassurés qu'ils étaient que le thérapeute qui leur avait offert ses services était toujours disponible.

Les formes atypiques, monosymptomatiques, pseudo-névrotiques de schizophrénie sont plus fréquentes; le vocabulaire même dont je viens de me servir est nouveau et date de dix ans à peine. Nous rencontrons fréquemment des malades qui présentent des symptômes hystériformes ou obsessifs-compulsifs, s'accompagnant d'un manque d'intérêt, d'introversion et de maniérismes étranges: cliniquement, nous sentons plus que nous voyons la schizophrénie dans ces cas.

D'autres, enfin, ont un comportement psychopathique qui sont en fait schizophrènes. A l'hôpital, ils présentent des problèmes de comportement, ils ont des épisodes où ils sont agressifs: si on les questionne sur leurs motifs, ils se contentent de hausser les épaules et repoussent l'explication qu'on leur propose. Hors du milieu hospitalier, ils s'adonnent souvent au vol, à la narcomanie, à l'homosexualité non déguisée, etc. Pour certains cependant, ce genre de comportement est transitoire; c'est par exemple, au cours d'une psychothérapie, l'assertion d'une capacité recouvrée à agir d'eux-mêmes. Dans ces cas cependant, ils sont plus ouverts et ont plus tendance à s'expliquer de leurs déviations des schèmes de comportement usuels.

En énumérant ces changements dans la présentation clinique des schizophrènes, je crois qu'il est essentiel de mentionner que la schizophrénie n'est plus caractérisée par la détérioration progressive. Elle peut évidemment évoluer vers la chronicité mais cette dernière est moins fréquente ou moins profonde. L'indifférence du schizophrène, symptôme de première importance, est beaucoup moins souvent rencontrée.

Comment pouvons-nous comprendre ces changements? On pourrait croire que les descriptions cliniques qui ont été faites dans les manuels, relevaient d'observations faites dans une salle de malades chroniques – c'est un fait que les manuels ont été écrits par des cliniciens attachés aux hôpitaux d'Etat et ont servi à la formation des psychiatres qui y travaillaient dans un passé encore récent.

On peut aussi croire que ces impressions cliniques, si elles sont acquises dans un milieu ouvert, ne correspondent pas à la présentation des malades qui éventuellement aboutissent à l'hôpital d'Etat.

Cependant, l'hôpital d'Etat améliore lui aussi ses statistiques, les cliniciens qui y travaillent montrent un plus grand optimisme thérapeutique, la communication du patient avec le milieu extérieur n'est plus rompue aussi violement qu'autrefois, une réalité sympathique "éperonne" continuellement le malade et prévient sa régression; la réhabilitation est plus fréquente et les collaborations pour la réaliser plus nombreuses.

Cette oscillation des symptômes, cette variabilité des formes, est d'un excellent pronostic. Si on regarde de près à cette hésitation dans les symptômes, on réalise que voilà justement ce que souhaite le thérapeute qui, après avoir soulevé l'anxiété du malade, le voit passer par exemple de l'indifférence à l'agressivité. Même si cela peut être temporairement ennuyeux, cela marque une progression par la reprise de contact avec la réalité, même sur un mode hostile.

Pour revenir à notre explication du changement des formes schizophréniques, pourrions-nous dire que notre meilleure compréhension de la structure de l'ego nous a fait découvrir ce qui a toujours existé au sein du malade et que jusque là il demeurait fixé dans sa régression par notre ignorance de son dynamisme et notre ineptie thérapeutique.

Réhabilitation

Les conséquences de cette évolution de la "symptomatique" schizophrénique nous posent à leur tour des problèmes de réhabilitation que nous allons maintenant envisager.

Si nous avons maintenant des malades moins régressés, si plus d'entre eux combattent leur maladie sur plusieurs lignes de défense, si les paranoïdes peuvent maintenir pour de longues périodes une façade de fière isolation tandis que la société les voit comme étranges mais "normaux", le problème de la réhabilitation s'accroît dans des proportions identiques.

A la fin d'une hospitalisation de deux mois, un schizophrène a pu retrouver un certain équilibre mais il n'a pas confiance en lui-même, il peut être *sain* mais il est isolé, il peut composer avec la réalité mais il est très sensible. On pourrait résumer ainsi sa situation:

– Les situations indifférentes sont trop nombreuses.
– Les bons objets sont trop rares.
–Les mauvais, de par la tradition, trop puissants.

Dans ces circonstances, le retour au milieu identique sans autre support du thérapeute, peut être fatal. Par ailleurs, si pour demeurer près du thérapeute, il laisse sa famille, on est assuré que tôt ou tard il y reviendra d'une inclination naturelle et sans avoir profité de la séparation. Les chances sont apparemment meilleures d'une réadaptation satisfaisante si le patient et le parent chez qui il retourne demeurent tous deux dans une situation de traitement, comme c'est le cas par exemple lorsque le parent voit régulièrement une travailleuse sociale qui lui interprète le comportement du malade tandis que ce dernier continue sa thérapie avec le médecin.

En fait, tout n'est pas mauvais dans le milieu d'où vient le malade. On est souvent enclin à la partialité vis-à-vis le malade ou vis-à-vis le parent. Plusieurs auteurs ont écrit récemment à ce sujet. On semble être assez d'accord pour considérer que le schizophrène ne réussit pas très bien seul. Ceux qui retournent chez des frères ou soeurs auraient plus de chance de s'y bien adapter que ceux qui retournent chez les parents. Une revision faite en Colombie Britannique des cas de schizophrénie rencontrés chez les vétérans du dernier conflit révèle que 21% d'entre eux se marièrent après la première manifestation de la maladie, que les ⅔ d'entre ces derniers sont hors de l'hôpital 15 ans après les premières manifestations schizophréniques et plus des ¾ auraient eu une bonne adaptation maritale.

Voilà certes un résultat auquel nous ne nous serions pas attendus il y a quelques années. Nous prenons maintenant pour acquit que beaucoup de schizophrènes quitteront l'hôpital mental. C'est un fait d'expérience qu'ils peuvent trouver dans leur milieu un mode d'adaptation. Nous devons faciliter les choses en étudiant avec les personnes intéressées la relation patient-famille. Nous en revenons bon gré mal gré en face de la réalité: la solution du problème ne réside pas dans l'échappatoire du placement mais dans la

solution des conflits là-même où ils se sont formés.

De plus en plus le rôle de la famille dans la réhabilitation attire l'attention. Brodey a fait une étude colossale de 5 familles "hospitalisées" en entier en même temps que leur membre schizophrénique. La famille entière, en tant qu'unité, a participé à des sessions journalières de psychothérapie.

Notre expérience personnelle nous conduit à pratiquer un travail de collaboration plus intense avec la famille. Ceci n'est pas facile: le principal obstacle c'est que nous n'avons d'ordinaire que des contacts individuels, fragmentaires avec ses membres. Nous avons l'intention d'introduire dans notre approche thérapeutique, pour qu'elle soit globale et rapide, l'usage d'une clinique volante, équipe psychiatrique qui se rend chez le malade chaque fois qu'il est question de l'hospitaliser. Ces gens se souviendront de l'aide efficace que nous leur avons apportée en période de stress et il sera plus facile par la suite de nous relier à eux par l'intermédiaire de la travailleuse sociale qui nous a accompagnés à ce premier rendez-vous. Tandis que le malade sera extrait temporairement de son milieu, le contact sera maintenu et au besoin servira de véhicule à une forme de psychothérapie de la famille qui facilitera éventuellement la réintégration du malade dans ce milieu durant les premières semaines du retour à la maison. Diverses expériences ont été faites de ce moyen dans plusieurs pays et malgré son coût initial élevé, il est reconnu qu'il a, en dernière analyse, sauvé du temps et des frais à tous les intéressés. Très souvent, en effet, l'abandon d'une expérience psychothérapeutique survient à la suite d'un déchirement insupportable que subit le malade lorsqu'il est divisé dans son allégeance à la famille et au thérapeute, chacun des deux s'interprétant comme opposés et hostiles l'un à l'autre. Ce moyen contribuerait à réduire la lutte secrète qui résulte entre la famille et le thérapeute d'un sentiment d'échec chez ceux-là et d'un ressentiment chez celui-ci de ce qu'il voit comme une interférence dans le traitement de la part de la famille. Le résident en psychiatrie de deuxième année, pour le protéger d'une vision trop théorique de la psychiatrie pourrait contribuer avec bénéfice à ce service.

Il nous semble que nous sommes bien près de combler la faille qui autrefois séparait l'hôpital du milieu, le thérapeute des figures importantes de la vie du patient, la faille entre le malade et l'homme sain.

Sur le plan de la recherche, psychiatrie et psychologie sociale semblent devoir se rencontrer. La nouvelle avenue de la psychiatrie sociale semble s'élargir tous les jours davantage. Redlich la définit: "L'étude dans un milieu donné des maladies psychiatriques et de leur traitement, prévention incluse: c'est l'exploration des systèmes socio-culturels et de l'impact qu'ils ont sur le phénomène psychopathologique."

Dans cette définition, les termes "maladie", "traitement" et "prévention" s'appliquent à l'individu tandis que le milieu est défini comme une réalité qui existe sans qu'on la qualifie de normale ou de pathologique. Il est sage de fixer des limites au phénomène pathologique; qu'on le voit comme étant le fait de toute une société et la responsabilité de s'adapter serait encore celle de l'individu. Des études extensives de psychiatrie sociale sont publiées, celle du Sterling County étant la dernière à paraître. Cette collaboration avec la sociologie apportera sans doute beaucoup à la psychiatrie et à l'hygiène mentale. On ne peut que s'en féliciter.

En terminant, j'aimerais faire quelques commentaires sur l'influence considérable qu'a eue sur le changement de visage de la schizophrénie le progrès pharmacologique. Nous devons une grande part de notre succès dans le traitement de la schizophrénie au progrès pharmacologique. Nous devons une grande part de notre succès dans le traitement de la schizophrénie aux différentes médicaments que la recherche neuro-physio-

logique nous a fournis. Nous pouvons attribuer aux "drogues-miracles" la diminution de l'anxiété non-manoeuvrable, qui tient le patient à l'intérieur d'un véritable cercle vicieux d'anxiété, d'hostilité, de culpabilité et d'acting-out auto-destructeur. Nous leur attribuons aussi le mérite d'avoir raccourci la durée de l'hospitalisation, d'avoir aidé à réduire la nécessité de la surveillance étroite, d'avoir raccourci cette interminable durée émotionnelle où le patient a le sentiment de ne plus avoir de contrôle suffisant sur ses pulsions.

Toutefois, si le schizophrène est un individu sans maturité, s'il ne fut jamais capable de se relier fortement à son milieu, s'il a une faiblesse de son ego qui l'a empêché de progresser vers la vie adulte, même si un "dommage cérébral diffus" ou une "faiblesse génétique" est invoquée dans son cas, on ne peut que lui souhaiter de rencontrer quelqu'un avec qui apprendre de meilleurs moyens de se relier aux autres. L'emploi des médicaments aidera ou corrigera la physiologie du sujet, la psychothérapie lui sera nécessaire pour en arriver à maturité. Les "tranquillisants" tranquillisent: on n'élève pas un enfant—et le schizophrène en est un—en l'enjoignant de demeurer tranquille.

Les neuro-physiologistes peuvent être orgueilleux de leurs succès. Le plus grand qu'ils ont atteint peut-être, c'est d'éveiller dans l'esprit des psychiatres des questions plus nombreuses quant aux interrelations du psychique et du physiologique; on peut souhaiter qu'après nous avoir donné des remèdes puissants, ils en viennent à accroître des connaissances physiologiques qui contribueront à nous assurer une hygiène du cerveau.

Au même moment, nous sommes heureux que la psychiatrie, branche de la médecine, n'apporte pas seulement une connaissance plus grande de la pathologie mais qu'elle contribue à une théorie du mieux-vivre, en intégrant ses conclusions, aussi fragmentaires qu'elles soient, avec celles fournies par les travailleurs sociaux, les sociologues et les anthropologues.

C'est pour beaucoup, en étudiant la schizophrénie que nous avons accru nos connaissances de la psychologie de l'ego. En appréciant les difficultés des interrelations humaines, nous en sommes arrivés à comprendre davantage les hommes et la société.

Summary

The author describes the changing aspects of schizophrenia. It seems that the paranoid and atypical forms are more frequent while catatonia is decreasing in frequency. As a consequence, the prognosis seems to be better and the treatment has had to evolve. The author feels that the greater knowledge of the psychology of the ego that psychiatrists have and the better understanding that is imparted to the family members, plus the physiological effects of the new drugs are responsible for this better prognosis.

ERNEST JONES IN TORONTO 1908 - 13

A fragment of biography

CYRIL GREENLAND, A.A.P.S.W.[1]

"Men are strong as long as they represent a strong idea; they become powerless when they oppose it. Psycho-Analysis will survive this and gain new adherents in place of these others. I can only conclude with the wish that fate may grant an untroubled ascension to all who have been discommoded by their sojourn in the underworld of psycho-analysis. May it be vouchsafed to the others to carry that work in the depths peacefully to an end".(1)

S. Freud, Feb. 1914.

The history of psycho-analysis, like that of religion, philosophy, art, and politics, is scarred by fanaticism, defection and schism. Writing in 1914 about the secessions of Adler and Jung, Freud ruefully points out that psycho-analysts, no less than their patients, are limited by their own repressions. Ernest Jones, both in his biography of Freud and in his autobiography "Free Associations" was unsparing in his revelations about the extent and character of the opposition to psycho-analysis and wrote with feeling about several particularly unpleasant experiences in which he was involved. Less attention was given to the fact that opposition is seldom a one-sided affair. This is not hard to understand since it is, of course, often very difficult to determine exactly who struck the first blow and why. The biographical material now available, however, illuminates brilliantly the dramatic interplay between the founders of psycho-analysis and those who opposed them. It is apposite that Ernest Jones, who struggled so vigorously to make psycho-analysis an objective science, should bequeath such a lively source of biography.

The opposition to psycho-analysis provides a rich field for study which deserves more attention than it has so far received. Ernest Jones, although the target for a considerable measure of hostility, was able to write of his experiences with almost scholarly detachment. "Freud" he said, "lived in a period of time when the 'odium theologicum' had been replaced by the 'odium sexicum' and not yet by the 'odium politicum' ". It will be for the future to assess which of the three should rank as the most disreputable phase in human history. For ethical reasons, and also because he feared reprisals in kind, Freud himself disdained to use analytical material as ammunition against his opponents. Instead, in his polemics, he relied, almost entirely, on logic and an unshakeable conviction in his own infallibility. Jones, being of another age, race and faith, was both a part of and apart from the "old guard"*. His unique position, as a participant observer, with a Welshman's frankness and fervour gave him advantages denied to Freud. He saw the opposition as being essentially due to human frailty and as a regrettable but inevitable reaction to an idea in advance of its time. It is perhaps mainly for this reason that Jones, at the cost of what undoubtedly would have been a brilliant scientific career, devoted his life to interpreting Freud, building up a strong inner-circle of disciples and establishing on a sound foundation an international organization. But for Ernest Jones, psycho-analysis might well have foundered long ago on the reef of internal dissention.

Perfidy, weakness and defection among the pioneers of psycho-analysis, has its parallel in the history of other such innovations. New ideas, particularly those which challenge traditional atti-

[1]Director of Social Work, Toronto Psychiatric Hospital, Toronto, Ontario.

*The "Committee" consisting of Ferenczi, Rank, Abraham, Sachs, Eitingon with Jones as Chairman was established in 1912.

tudes, are threatened by inner, as well as outer, stresses. Outwardly there is always the inexorable conservatism which resists change, except when it is gradual and inevitable. Then there is among some exponents of new ideas a noisome excess of enthusiasm which rarely fails to vex even the most amiable of men. Often there is also an aggressiveness which in effect, at least, is not unlike the threatening noises animals make to protect their young from real or imagined attack. In humans this form of paranoia is not only defensive and compensatory, but it is at the same time self-aggrandizing and a means of display.

In recent, as well as in ancient times, religious and political movements have deliberately exploited persecutory ideas and extreme provocation to gain attention. New movements also attract to themselves a lunatic fringe of sensation seekers. Although they may embarrass the more stable elements, their extreme attitudes and provocative behaviour are not without value, at least in the beginning. History teaches us that such individuals and such artifices consciously used are often devastatingly effective and invariably malignant. Freud certainly knew this and had more cause to fear his over-zealous followers than the opprobrium of his adversaries.

Extremist elements in new movements are easily identified. Usually they lack tenacity and prove only a temporary embarrassment. Identification with a movement as a means of self-display, however, presents a peculiarly different problem. With such individuals the need to gain attention may actually be inseparable from the elements of militant and unselfish devotion. It may, in fact, be virtually true, as Freud indicated in the quotation with which this paper begins, that without a cause man suffers a loss of identity. In this sense belonging is synonymous with being. That this may have been particularly true for Ernest Jones, is suggested by some otherwise puzzling aspects of his behaviour as a young man.

Speaking of his youth, in the Second Volume of his biography of Freud (2), Ernest Jones reveals with disarming frankness that among others he was deprived of his means of livelihood because of his adherence to psycho-analysis. "I was," he writes, "forced to resign a neurological appointment in London for making inquiries into the sexual life of patients". He continues, "Two years later (1910) the Government of Ontario ordered the Asylum Bulletin to cease publication. It had been reprinting all papers written by the staff, and my own were declared unfit for publication', even in a medical periodical". Since all those involved are dead, the first assertion that he was forced to resign cannot be challenged, though it will be commented on later in this paper. The second statement, that this publication was suspended, presents less of a problem. It was easy to ascertain that Dr. Jones was wrong and that the "Bulletin of the Ontario Hospitals for the Insane" was in fact published continuously from 1907 to 1916, that is, from one year before he arrived in Toronto until three years after he had returned to England. This lapse of memory and retrospective error is, of course, entirely understandable in a man of seventy, writing about events of forty years before. It is, however, unlikely that Ernest Jones, who was meticulous in the extreme in his regard for scientific facts, would have accepted such a feeble excuse. Instead, he would almost certainly have searched for some less convenient but more exacting explanation of his mistake. This in effect is the main purpose of this fragment of biography of the early days in the life of a great pioneer.

In his own partial biography,(3) Ernest Jones, looking back to his younger days, remarked on his truly prolific literary output during his six years in Toronto. It was at this period that he made his most enduring contribution to

psycho-analytical theory with the publication of "Hamlet and Oedipus" and "On the Nightmare." Before the age of thirty-five he had produced no less than thirty papers on a wide range of medical and scientific topics. He not only wrote papers, but also presented them extensively to Medical Societies in North America. During this period he occupied a number of posts on the University of Toronto staff. Between 1909 and 1913 Dr. Jones was Demonstrator in Pathology and Medicine, as well as Associate in Psychiatry and later Associate Professor. He was also Pathologist to the Toronto Hospital for the Insane and Director of Toronto's first Psychiatric Out-Patient Clinic. None of these posts were sinecures. In addition to all this Ernest Jones was co-editor with C. K. Clarke of the Ontario Hospitals Bulletin. As will be seen later, this last fact is of some importance in the context of this paper.

At this point it needs to be made clear that Ernest Jones was unhappy in Toronto, and attributed his remarkable industry to this fact. He remarked, "However enterprising I might be intellectually, I was not intended for a pioneer's life in a new country". He found that Englishmen were not paritcularly popular. They were known as "broncos" because of their habit of "kicking", criticizing their new environment. In face of this attitude, Jones fell back on his Welsh origin and "resolved at all events not to be a 'bronco' for sensitiveness to criticism was plainly a national characteristic". How far he succeeded can only be surmised but it seems that he made few Canadian friends and on the whole found them naive and unimaginative. He admitted also to a home-sickness for Europe which he indulged by dashing there at every opportunity and by joining the German Club in Toronto. The weather did not suit him either. "More serious", however, said Jones, "was my attitude toward the intellectual atmosphere. It was not merely that I found myself back in the Biblical and Victorian atmosphere of my boyhood—that would be bad enough to someone bent on emancipation—but it was the dead uniformity I found so tedious; one knew beforehand everyone's opinion on every subject, so there was a complete absence of mutual stimulation or exchange of thought".

It can be assumed that his feelings for Canada and Canadians were largely reciprocated and that, despite or possibly because of his industry and brilliance, Ernest Jones was not popular. "Toronto the Good" prided itself and still does on the high moral tone of its city and the virtue of its citizens. Ernest Jones, came from the "old-country", like so many before him and possibly since, with a reputation, however undeserved, for sexual excesses of the worst kind. Worse still, he set up house in Toronto with his elder sister and "Loe", who was his mistress* for a number of years. Such behaviour was hardly wise in a public figure and a champion of a new cause. Not surprisingly, Freud personally ended this *affaire* by taking "Loe" on for treatment in Vienna and sending Jones off to Italy for a holiday. Freud's treatment was eminently successful and eventually both were happily married but not to each other.

This excursion into Jones' private life helps to outline the background against which the man and his ideas were judged. Curiously enough his writings, possibly with a single exception to be mentioned later, give no indication of unconventionality or erratic brilliance. Their prodigious quantity impresses one with his industry and erudition. Of his numerous articles reprinted in the "Bulletin of the Ontario Hospitals for the Insane" only four refer to Psycho-Analysis. None of these was originally prepared for a Canadian audience. The first,

*"She took my name, and we would frequently visit our respective families as a married pair." "Free Associations," p. 50.

in chronological order, "Psycho-Analysis in Psycho-Therapy", a remarkably restrained paper was read by Dr. Jones at a symposium on Psycho-Therapy, under the auspices of the American Therapeutic Society, New Haven, May 7th, 1909. Far less cautious was his "Psycho-Analytic Notes on a case of Hypomania", first published in the American Journal of Insanity, Oct. 1909, p. 203. As will be shown later its reprinting in the "Bulletin" in Oct. 1910 probably aroused a great deal of indignation in Toronto. The next paper "Freud's Theory of Dreams" was presented to the first Annual Meeting of the American Psychological Association, Dec. 29th, 1909. "The Therapeutic effect of Suggestion" was presented to the first Annual Meeting of the American Psycho-Pathological Society in Washington, May 2nd, 1910. In this unassumingly pedagogical paper Ernest Jones traces the development of hypnotism and describes the work of Bernheim, Sidis, Charcot, etc., as precursors of Freud.

Ernest Jones was not always, however, the most tactful of men. For example, as co-editor of the "Bulletin of the Ontario Hospitals for the Insane," it might have been considered prudent of him not to monopolize its pages. We find, however, that Bulletin No. 3, March 1909, Vol. II contains three articles; the one by Jones on "The Cerebro-Spinal Fluid in Relation to the Diagnosis of Metasyphilis of the Nervous System", occupies twenty-four of the fifty available pages. No. 4, March, 1909, Vol. II contains ten articles, eight of them by Jones. In No. 5, April, 1910, Vol. III, seven out of ten articles are by Jones. Bulletin No. 1, October, 1910, Vol. IV, unlike earlier editions, does not include the names of the editors but carries ten articles, three of them by Jones. However, his name is singularly absent among the contributors to subsequent issues. Conceding that all his articles were of undoubted value and their reprinting fully justified, it is clear that Jones' virtual monopoly and extravagant output would hardly have endeared him to his colleagues, contributors and subscribers. This error of judgment, however, is in itself hardly enough to warrant the Ontario Government's intervention and one must look elsewhere for the cause of this exasperation.

Without access to Provincial Government archives it is not possible to say with certainty which particular incident, if any, lead to Dr. Jones being removed from his position of co-editor. Indeed apart from his own erroneous assertion that the publication was banned and the fact that his name does not appear in Bulletins after 1910, there is no obvious evidence of interference of any kind. Yet, it would be artless to assume that Dr. Jones' reproach was altogether without foundation. The most plausible explanation is that there was no single insult but that one article alone gave the authorities the opportunity they were seeking to reprimand Jones, whose attitude and opinions they found repugnant. This belief is supported by the fact that with the single exception to be noted, all the publications by Jones in the Bulletin conform to the highest standards of propriety in that reference to sex is obscure and circumspect.

The paper in question, "Psycho-Analytic Notes on a case of Hypomania" departs from Ernest Jones' usually high standard of scientific objectivity. Psycho-Sexual concepts are introduced to which, even today, many professional people will take strong exception. In his introduction, Jones points out that although fifteen years old the psychoanalytic methods developed by Freud have been singularly neglected outside of German-speaking countries. "These methods", he writes, "are unquestionably destined to have a far-reaching influence, not only in the case of the psychoneuroses but in much wider fields and particularly in that of insanity". Referring to the monograph by Jung (4), "The Psychology of Dementia Praecox," Jones describes it as a brilliant success

which should greatly encourage workers in this and allied fields of investigation. But up to that time, said Jones, no psycho-analysis of a case of manic-depressive insanity has been recorded. The one published under that name by Otto Gross (5), as Jung among others pointed out, was almost certainly a case of dementia praecox. Dr. Jones goes on to note that the same objections may be raised in regard to his paper but that in his opinion the evidence seems to point against that diagnosis.

The case was first described on classically Kraepelinian lines. Three possible diagnoses were considered, "manic-depressive insanity", "dementia paranoides", and "hysteria". The last was excluded because of the absence of expected physical signs or symptoms. The diagnosis of dementia praecox was weighed carefully and finally discarded because no evidence of the peculiar "shut-offness" or loss of contact with the immediate environment was present. Nor were there any somatopsychic perversions, such as stereotypies, verbigerations or mannerisms, etc. On the other hand, he argues, "there was marked alternation of depression and excitement, logorrhea, suggestibility during the excited period, retained insight, association reaction and typical manic flight of ideas which strongly support the diagnosis of manic depressive psychosis".

The presentation along Kraepelinian lines was then criticized on the grounds that it gave a conception of the disease as seen from the outside, from the point of view of the clinical observer. "It does not pretend", says Jones, "to lead us to an appreciation of the mental phenomena as seen from the inside". The advantages of the psycho-analytic method were then discussed. "We are", he says, "for the first time beginning actually to penetrate into the patient's mind and to learn something about the patho-gnomonic mechanisms by means of which the different symptoms of the disorder are brought about." He warned that the psycho-analysis of an individual case of any psychosis was so difficult that it was rarely complete. The present case was then considered on the basis of a few association tests. These revealed a high percentage of superficial association, mostly clang and motor–speech forms and a markedly erotic assimilation shown in regard to most of the stimulus words. Of particular interest was the striking similarity between the result of the two examinations given a month apart.

In the first examination sexual orgasm was provoked by the stimulus "spent", "come", "spirit". In the second, orgasm was provoked only by "spent". In the third a similar effect was achieved by "spent" and also by "mount", a stimulus not previously included. On the basis of these association tests and the patient's association reactions which will be referred to again, Ernest Jones made the following case synthesis.

"A woman, of passionate temperament and strong religious training, had at the age of sixteen been seduced, and at the age of nineteen had married another man by whom she was already pregnant. After bearing one child she had a miscarriage, which she attributed to a gonorrhoea contracted from her husband, and underwent a number of gynaecological operations and other treatment for the relief of subsequent pelvic complications; her ovaries were removed at the age of twenty-three. As the years went by, her desire to have more children was strong, and her sexual inclinations increased in intensity; at the same time her husband's capacity to gratify these grew less, and she contrasted him unfavourably in this respect with her former lover. She thus blamed her husband twice over for her lack of children. She had illicit relations with other men, which caused her much remorse. Religious appeals to forsake her evil ways and lead a new life she interpreted as a revelation indicating the error of her past sexual life and advocating a new form of sexual life. For a number of reasons this idea of a new

sexual life took the form of the fellatorism perversion. She tenderly loved her husband, so that there arose in her mind an intense conflict between this feeling of love and duty, and the forces impelling her to turn from him to a new kind of life. The compromise between the two sets of forces was found in identifying, for a number of reasons, the act of fellatorism with the partaking of the holy sacrament. A number of abnormal mental processes were the direct outcome of this; such were delusions of poisoning, refusal to take food, intense excitement evidently of erotic origin, belief that various ministers were in love with her and eager to lead her into the "new way" of sexual life, etc. These abnormal processes clinically constituted recurrent attacks of mania."

Between the association tests and the concluding case synthesis Jones speculated, albeit rather dogmatically, on the sexual etiology of the patient's illness. Sparing none of the finer details he describes her seduction at the age of sixteen by a music teacher, who, Dr. Jones gratuitously reports, on several occasions had sexual intercourse with her over a dozen times in one night. After marriage her sexual demands reached nymphomaniac proportions, by far exceeding her husband's capacity to satisfy them. Since she could not be adequately gratified by her husband, she turned to the Church. Interpreting very literally appeals from the pulpit to forsake her evil ways she assumed that she had been indulging in sexual gratification the wrong way. In veiled language one Minister revealed to her that the true way was to admit the male organ not into her vagina but into the mouth. "The seed was in this way to enter into the body—had not Christ said "Take and drink"?—where it would perform its function of creating and nourishing the child".

Dr. Jones continues in this vein:—"When speaking of religious observances, particularly of Holy Communion, the patient broke off, and slowly and reverently went through a perfect pantomine of the whole ceremony. This culminated in her taking a glass of water, which she had placed on a Bible, and gradually raising it to her lips, where she beatifically sucked the rim, slowly revolving the glass as she did so. During the latter part of the performance a complete and exhausting orgasm took place. I pointed to the glass, and asked her if it was the communion cup; she answered: "Do you call it a cup? It has another name", and later remarked: "This is the Way, the Truth and the Life", etc.

Among the cognoscenti, interpretations of this kind may be meaningful, but it is not difficult to imagine the degree to which the medical profession in the Ontario of 1910 was scandalized by them. Apart altogether from the obvious dangers of being regarded as the author of a lascivious work the interpretations themselves can be criticized on the grounds that they are based more on predilection for a certain order of explanation than an impartial judgment of facts. To say the least, the symbolic interpretation in this case of the Holy Sacrament as a perverse sexual act is arbitrary. No attempt appears to have been made to consider the merits of possible alternative explanations. Other similarly dogmatic formulations are equally contentious. Referring to the patient's orally erotogenic proclivity, Dr. Jones says that with some people the mouth is the equivalent of the vagina and continues:—"This is, of course, as a rule, accompanied by marked sucking movements, and the earliest source of this abnormality has been clearly traced by Freud to the sucking movements of the infant at the nipple. Children destined later to show this abnormality are morbidly fond of sucking various objects, particularly their own toes or fingers."

It may be argued with good reason that, however unpopular his methods or findings, Dr. Jones had the right, even a duty, to pursue whatever line of enquiry he desired. This even in a case which

from the outset he knew to be extremely difficult and impossible to complete. Accepting this, the very tentative conclusions which resulted seem suitable only for discussion with like-minded colleagues or at best for brief notice in a psycho-analytical publication. In fact, the article first appeared in the American Journal of Insanity, Oct. 1909. It is more difficult to understand why Dr. Jones, as co-editor, allowed it to be reprinted in the Bulletin of the Ontario Hospitals, thus exposing himself to the contumely of his peers and superiors. It certainly was not that he lacked experience of such difficulties, for in 1906, although undoubtedly innocent, he was actually charged with indecent assault on two young girls*. Afterwards he referred to the "ineffaceable stain" and said that he would never be the same as before that most disagreeable experience of his life. Again in 1908 there occurred a similar painful episode with a girl of ten. Shortly after her interview with him the child boasted to other children in the ward that Dr. Jones had been talking to her about sexual topics. As a result Ernest Jones was called upon to resign from the hospital staff.

With these two fearful experiences behind him one would expect Dr. Jones to have been far less intrepid. This imprudence raises questions such as, was his judgment impaired by an excessive enthusiasm for psycho-analysis? Was it an unconscious desire to provoke hostility? Or was it simply a determination to seek emancipation from a way of life which he found narrow and constricting? No answers are offered and at this point it is possible only to formulate these tentative questions. In all probability, Dr. Ernest Jones would have considered this to be not an unimportant first step.

Freud described Jones as an "unflinching and steadfast" champion of psychoanalysis, and it seems appropriate to conclude with a quotation greatly admired by Ernest Jones. It aptly describes his unique contribution to the good of mankind:

> "Happy is he who can search out the causes of things, for thereby he masters all fear, and is throned above fate."

*See "Free Associations", p. 145.

References

(1) Freud, S. "On the history of the Psycho-Analytical Movement" Collected Papers Vol. I, p. 359. Basic Books, New York, 1959.
(2) Jones, E. "S. Freud, Life and Work", Vol. 2, p. 122-3, Hogarth Press, London, 1955.
(3) Jones, E. "Free Associations", p. 192, Basic Books, New York, 1959.
(4) Jung, C.* "The Psychology of Dementia Praecox" J. Nerv. and Ment. Dis. Monograph, 1909.
(5) Gross, Otto*. Des Freud'Sche Ideogenitatsmoment und Seine Bedeutung im manisch-depressiven Irresein Kraepelin's 1907.
*Quoted by Jones, E. Am. J. of Insanity p. 203, Oct. 1909.

Résumé

Le Dr Ernest Jones, ami de Sigmund Freud et pionnier de la psychanalyse, quitta l'Angleterre, où il était en proie à beaucoup de difficultés, et vint travailler à Toronto. Il fut nommé au personnel de l'Université de Toronto comme démonstrateur en pathologie et en médecine, associé en psychiatrie et plus tard, comme professeur associé.

D'après ses propres dires, son séjour ici de 1909 à 1913 lui procura peu de satisfaction. Ce fut toutefois, la période la plus créatrice de sa vie. Avant l'âge de 35 ans, il avait déjà rédigé pas moins de trente communiqués traitant de toute une série de sujets médicaux et scientifiques.

A Toronto, Ernest Jones éprouva de nouveau toutes sortes de difficultés et beaucoup d'opposition à ses opinions. A l'époque, il était corédacteur en chef du *Bulletin of the Ontario Hospitals for the Insane*. Donnant un exemple de l'hostilité manifestée envers la psychanalyse, le Dr Jones déclara que la publication de ce Bulletin avait été suspendue par le gouvernement ontarien parce qu'il y avait des articles qui "ne convenaient pas à la

publication même dans un périodique médical".

L'article ci-dessus examine ces faits et démontre que le Dr Jones se trompait. De fait, la publication ne fut pas suspendue. Il semble cependant qu'un article du Dr Jones intitulé "Notes psychanalytiques sur un cas d'hypomanie" ait fourni aux autorités l'occasion qu'elles recherchaient de le réprimander.

On passe brièvement en revue l'article en cause, et on laisse entendre que le Dr Jones était beaucoup moins prudent qu'il aurait dû l'être. De fait, il semble y avoir des indices que l'auteur, de propos délibéré, cherchait à provoquer les gens. On en conclut que l'opposition à la psychanalyse dont parle le Dr Jones revêtait deux aspects: une antipathie naturelle envers les idées nouvelles, et aussi l'excès irritant d'enthousiasme de la part des protagonistes d'idées nouvelles. Freud avait plus raison de craindre ses disciples trop zélés que l'opprobre de ses adversaires.

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PSYCHIATRIC THEORIES OF ALCOHOLISM*

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The various psychiatric theories of the causes of alcoholism are almost as diverse as some of the common conceptions or misconceptions held about psychiatry and the psychiatrist. One often hears fears expressed by the patient about the role of the psychiatrist in dealing with the alcoholic. Closer questioning may reveal that, on the one hand, the person still holds to the almost mediaeval idea that the psychiatrist is the custodian of an institution to which the unlucky patient is confined or committed for the rest of his days; at the other extreme is the fear, often masked by humour and amusement, about what is expected of the patient when he submits himself on the psycho-analyst's couch. One can assume this is related to patients' denials of psychological conflicts and their desire to proclaim a purely physical disturbance to account for unhealthy drinking.

The traditional way of looking at any problem of emotional illness is to concern oneself with first the constitutional factors, including the contributions directly related to heredity as well as alterations of structure and functions; second, the psychological attitudes acquired as a result, constitution and various developmental experiences; and third the influence of immediate environmental or social factors.

If there is any basis for thinking of a hereditary foundation for personality characteristics unique to the alcoholism as an individual, we must assume it to be an extraordinarily complex one with none of the direct relationships that we are aware of when we consider the inheritance of such qualities as eye colour, height, body habitus or even, as in certain illnesses such as Huntington's chorea. What it seems we can accept is that there are certain inherited differences in the temperament of individuals in which the person may be seen as cheerful, irritable, aggressive, out-going or dull and phlegmatic. And, we generally accept that there is an inherited factor in intelligence which is often narrowed down to quite specific skills. Presumably, any of these characteristics might alter the way in which the person would react to difficulty and perhaps play some part in the influence alcohol could exert on him; thus the anxious may be soothed, the rebellious encouraged and the unexcited or dull provided with phantasy.

We shall not consider here the possible inherited differences in either tolerance or sensitivity to alcohol, although it is reasonable that there well may be some differences in individual reaction which permit more easy release for some persons from their ordinary degrees of control; a release which is emphasized in the presence of severe emotional conflict. This may be almost entirely a function of weight and body structure rather than a true difference in tissue response. Even such evidence as there is to suggest an increased tissue tolerance with repeated dose does not imply a gross range of many times the original capacity as with some other drugs, particularly the morphine derivatives.

The Alcoholic Personality (1)

Since we feel that the nature of personality for most of us is established relatively early on, this seems a reasonable point to say something about the concept of the alcoholic personality. In a thesis published in 1947, Quaranta (2) described the alcoholic as a person "unstable, disorganized, unnecessarily anxious and easily depressed. His actions

*Prepared for the Yale Summer School of Alcohol Studies, July 4, 1960.

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are not guarded by the high tribunal of critical ability but rather driven compulsively. He tends to be oblivious to ordinary social sanctions and acts on rash impulse and fails to grasp the depths of what most people hold dear". Many of us will feel that these ways of behaving are met with remarkable frequency in the alcoholic population. To conclude, however, that this describes the alcoholic would be premature. When we look at a variety of studies discussing a supposed specific personality type, we find that very often the description given is peculiar to the particular experience or setting in which an investigator is operating at the time of collecting his information. The descriptions then made of the so-called alcoholic personality frequently embody quite diametrically opposed ideas when one compares one study to another. Thus, despite the fact that we may each feel from our own experience that certain constellations of characteristics are seen much more frequently in certain groups of alcoholics than one would expect in a normal population, we must, nevertheless, agree with Syme (3) who states, "There is no warrant for concluding that persons of one type are more likely to become alcoholic than another type. Much more thought and research is yet needed before any extreme position can be justified in this area."

Psychoanalytical Theory

As we begin to look at some of the specifically defined theories we find that the psychoanalytical schools have probably presented us with the most precisely delineated concepts. Although we may not always agree with them, we can at least examine a few fairly clear cut hypotheses. Chafetz (4), writing in the Quarterly Journal, has summarized a number of dynamic formulations. "Freud (5) alluded to strong oral childhood influences as a cause of excessive drinking and considered change of mood the most valuable contribution of alcohol to the individual. His thesis was that under the influence of alcohol the adult regresses to a childhood level in which he derives pleasure from thinking which is unrelated to logic". Perhaps here Freud was thinking of the compulsive, humorless individual who cannot let himself regress through his imagination under any circumstances. "In later papers Freud spoke of a reactivation of repressed homosexual traits and considered this to be the reason why men disappointed by women frequented bars."

Brill (6) considered alcoholism as a flight from homosexual impulses, incestuous thoughts and masturbatory guilt. Jones (7) suggested that alcoholism is a symptom of epilepsy and psychosis, while Glover (8) related addiction to sadistic drives and oedipal conflicts. Sachs (9) viewed alcoholism as the compromise between hysterical and obsessive compulsive neuroses, while Rado (10) suggested that alcohol addiction is mainly a problem of depression, the alcohol producing pharmacologically a magical sense of elation which the patient craves. Menninger (11) emphasized the self-destructive drives of the alcoholic and termed alcoholism "chronic suicide". Tiebout (12) believes that the alcoholic has an unconscious need to dominate, together with feelings of loneliness and isolation, while Knight (13) considered that the addictive alcoholic suffers basically from a character disorder distinguished by excessive demands, an inability to carry out sustained effort and feelings of hostility and rage, alcohol being utilized to satisfy and pacify the alcoholic's frustrated needs". All of these people carried out intelligent and careful observations on the cases they reported, and obviously, what they described then as the alcoholic was one of the kinds of persons who can find this substance a convenient or ready vehicle for the exploitation or expression of their own particular personality problems. It seems to me that in thinking

of character disorders, we forget one of the simplest ones which perhaps could well be called pre-oral in which the infant has not yet learned to distinguish or be sensually aware of the warmth or love of his mother as symbolized in the oral concept but is still in the stage where only the crudest gratifications are available to him. And perhaps, what is more important, these are available to him in response to his own demands; a situation which never seems to leave many of our alcoholics whom we see in later life and for whom alcohol provides an instantaneous gratification which may or may not be equitable to the warmth and love of the mother's breast as implied in the concept of orality.

Levy (14), also writing in the Quarterly Journal, likewise points out a number of dynamic functions that are well served through the use of the drug Ethyl Alcohol and he lists first: i) discharge function; with the blunting of anxiety, guilt and shame, permitting expression of various impulses which otherwise do not fit the patient's overall picture of himself; ii) narcotization: when a barrier is needed to prevent intrusions from the world of reality as in the Skid Row population; iii) symbolism: by which one achieves status, masculinity, omnipotence, etc. through the act of drinking or becoming drunk; iv) infantomimetic functions which can generally be equated to the idea of pathological oral gratifications, in which there is need for repeated sense of being loved or satisfied; v) masochistic functions, which perhaps would be similar to Menninger's idea of self-destruction; vi) hostility, perhaps to be equated to Glover's idea of sadistic drive but certainly a vehicle for the rather diffuse and poorly organized hostility which characterizes many alcoholics; vii) homosexuality, latent or overt: perhaps the very fact that both the overt homosexual and the latent homosexual can use alcohol to subserve the needs of their problems clearly demonstrates the diversity of roles which this drug can play; viii) identification: identification is a mechanism by which we take on characteristics of parent or parent model whether or not we consciously accept the person or their behaviour. Thus one may emulate a drinking parent by drinking oneself as an expression of hostility or rebellion to that same parent. Those of us with any extensive experience recognize all of the above patterns in our patients.

Actually in each individual case the alcohol may serve in several roles at once; i.e., release of anxiety, satisfaction of oral needs, and substitution or sublimation of otherwise unsatisfactory or unacceptable sexual drives.

Rado (10), in his article the Psychoanalysis of Pharmocothymia, published in 1933, laid stress on the fact that up until then most writing described all the phenomena of alcoholism in terms of toxic effects of alcohol. He was particularly concerned with the elatant effect of alcohol and, I believe, felt this could be applied more than merely to the depressed. Alcohol becomes a unique source of satisfaction, elation, achievement for many whose lives otherwise for personal, historical or environmental reasons, are ridden with boredom, frustration and disappointment.

Rado also lays great stress on the ease with which alcohol permits fulfilment of megalomanic drives of the infant, uncurbed and undifferentiated, in which he is the master of a disorganized world centred on a yet almost undefinable ego structure. Rado suggests that the alcohol then reinforces the individual's sense of vulnerability and hence makes him impervious to the blandishments of family, medical advisors and other experts. Some of the best examples of such personalities are described by Cleckley in his book, Mask of Sanity (15).

The idea of latent homosexuality is proposed by many writers. Perhaps it is best to recall that repressions of various kinds are normal to all our development and those that are least happily resolved

may come to the fore under the influence of alcohol or alcohol may be an adequate substitute. Abraham (16) gives the rather homely example of the minor evidences of physical affection which many males may show under the influence of alcohol. If such demonstration is clearly taboo, otherwise, as Suttie (17) suggests for some cultures, it may be that alcohol provides the only permissible release.

When it is impossible ever to face the unacceptable in one's sexual behaviour, at whatever level, overt, or passive, then the drinking may constitute a perversion in itself, a complete substitute for any kind of sexual expression.

Now, just a word about the female. Most of the remarks above sound as if they were directed only towards the male. This is somewhat justified by the apparent high ratio, anywhere from 4:1 to 8:1 of male to female alcoholics. This may be partly related to differences in expectations and attitudes exerted by one or other parent on the male or female child. At the same time, many general problems face the female in just the same way as they do the male; in fact, as we well know, there is a large group of females faced with the challenge of having to direct themselves for one reason or another into a role comparable to what they consider the favoured position of the male. Often, this means emulating the male even in such behaviour as the way in which he drinks. It may be, on the other hand, that one commonly suggests that the much smaller ratio of female alcoholics to males has to do with the greater acceptance of heavy drinking pattern among the male elements of the population. Traditionally, in most cultures it is assumed that masculinity should be equated with strength, aggressiveness, domination. The taking of alcohol in some way simulates or symbolizes strength and potency. However, it may be that there are factors which actually protect the female from some of the stresses which seem to make alcohol use in pathological degree desirable, although the evidence for this, in terms of total psychological disorder among females as compared to males, probably does not bear this out. There is also some suggestion that in our culture, at least, sedatives and nerve pills are now acceptable as a means of habituation for the female.

Learning and Culture Patterns

While this aspect of the problem is undoubtedly the prerogative of the psychologist just as the study of the culture in which the individual is operating is that of the sociologist, they must be mentioned since one of the great reasons for confusion in trying to interpret the meaning of most psychiatric surveys has been the attempt to look at ideas isolated from the context of other factors, the isolation being so complete as to encourage and often justify attempts to discredit the significance or value of certain psycho-dynamic formulations with reference to the individual alcoholic.

We are all familiar with the fact that we have incorporated into our scheme of living various habit mechanisms. These are mechanisms which have impressed themselves on us, either through their early place in our attention, their intrinsic importance or their repetitiveness or other factors, in such a way that eventually they become almost automatic responses under certain circumstances. Examples of this are the order in which we put on particular articles of clothing or, in fact, the ease in which we go through the intricacies of such manoeuvers as tying a shoe lace without being consciously concerned with any of the individual actions involved. Many of these habits are extremely useful to us but at the same time, some of us pick up unpleasant patterns or extraneous components to other useful habit mechanisms that are quite unhelpful.

Some habits, of course, become learned responses to unpleasant situations and may involve the formation of fairly

complicated psychological reaction mechanisms. Many of these can become part of the pattern of dealing with unpleasant or unsatisfactory situations in the parent-child relationships. Unfortunately a similar pattern of resistance or rebellion avoidance or defeat may become the consistent responses to similar situations in which one is dealing with any parental substitutes in later life. Now when it comes to the use of such substances as tobacco, coffee, or alcohol, or unnecessary amounts of food as the pattern of reaction, one presumably can through simple repetitive experiences come to use these substances in a rhythmic pattern without being fully aware of the actual behaviour that is going on. Some of this, of course, could be simply learned from the example of the culture through fitting into the general custom of one's surroundings. In other instances, there is an individual response pattern that permits this habit to change. Thus, conceivably, a person without too much complication in his own life may accept a pattern in which he consistently smokes too much, drinks too much coffee, eats too much food, or as we know, drinks too much alcohol. He may also learn that food or alcohol provides a useful relief, escape or substitution for an unpleasant situation. If we combine the factors of psychological stress and habitual or customary response then there is considerable possibility of leading one to a serious pathological state. If we think for a moment of the special qualities of alcohol, as a person learns of its use, we are at once struck in many cases with the fact that the alcohol produced for the individual a very special, useful, and to him, desirable or unique response. If we are considering the person, and here I am thinking of the individual who perhaps falls into our group of character neurosis where the life pattern has brought about it many frustrations or feelings of inadequacy and undesirable reaction patterns, then the advent of the chemical alcohol may well produce a very uniquely useful experience for that person. Closely allied to this, of course, is the fact that alcohol, by and large, provides a pleasant and pleasurable experience. Custom permits that this use be repeated on various occasions and this is re-inforced by finding situations in which this special pleasure can be experienced in various new settings.

Let us also remember, when we are dealing with a psychological mechanism in the alcoholic, whether it is one due to some psychodynamic situation or a long established habit or whatever combination, we cannot entirely distinguish this from some kind of physiological change that may be taking place due to the effect of prolonged alcoholic exposure or due to some intrinsic sensitivity of the organism to alcohol.

Culture

We cannot completely divorce our psychological concerns from the setting of the culture in which the patient is operating. We find that alcohol has varying acceptance in particular cultures or sub-cultural groups. We can speak, if we like of high, medium and low acceptance groups for use of alcohol as a beverage. In the high acceptance group we may find the regular user who is seldom drunk but depending on the quantities involved in his regular use or some intrinsic individual factor that we don't know about, in time he may become an uncontrolled or deteriorated drinker. Some high acceptance groups may not be daily drinkers but accept regular drunkenness as part of the pattern. In either of these groups, we certainly may find the emergence of a fairly easy dependence on alcohol simply through a learned pattern of what is commonly accepted in that individual's associates.

By a medium acceptance group, we might be thinking of people who use alcohol with some regularity but in smaller doses with drunkenness a rare phenomenon. Certainly, in this group,

when stress occurs it is conceivable that alcohol may be turned to as an available source of relief, with repeated use as long as the stress persists. While the likelihood of reversal is possible with the removal of stress, there is also considerable chance of increasing dependence and the self perpetuating, deteriorating destructive pattern we call alcoholism.

In the low acceptance group, we often find that alcohol if used at all carries with it a certain aura of bravado or rebellion or surreptitiousness uneasiness, a pattern which may well lend itself to the confused needs of the neurotic individual, particularly when his neuroticism is so painful that it demands relief. Also, where there is a clear cut taboo or near taboo on the use of alcohol, it is plausible that alcohol becomes used as a kind of weapon of rebellion and thus has satisfactions beyond its own intrinsic pleasures; especially since drunkenness may encourage more overtly rebellious behaviour which would not take place when sober. Also, in the low acceptance group, we must recognize the fact that if drinking in itself carries with it a component of guilt then drinking may readily become associated with various situations and behaviour which is also guilt producing, but which cannot be readily evaluated by the individual because of his neuroticism.

The Combination of Psychological, Social and Physiological Factors

The problem, therefore, is how to fit the psychological theories into the total framework. Again, it must be recognized that a common fault inherent in the approach of the scientist is that he commonly wishes to deal with single factors in isolation. Unfortunately, our experience in dealing with this multifaceted problem suggests that there is no particular area that seems to stand out more than another. The emergence of the problem of alcoholism is dependent not only on the psychodynamics patterns of the person but on the cultural pattern which he has accepted and on some, as yet poorly defined, individual indifference in his own make-up. Now, in the social groups mentioned before, we find that on one extreme will be the group in which there is extremely high acceptance of alcohol use with a pattern of regular usuage in large amounts so that with sufficient exposure, perhaps related to some heightened sensitivity of the individual, we may have a problem with very little in the way of psychological complications. But, at the other extreme, in the groups where there is very low acceptance the situation is reversed in that we may expect to find a high frequency of personality problems, among those individuals who become pathologically dependent on beverage alcohol. While we commonly think of the neurosis or the character disorders in the background of alcoholism alcohol serves a purpose frequently in depressions, to a lesser degree in schizophrenic and the organic status, in fact any of the psychiatric syndromes.

Complications

Now, having suggested a mechanism by which a person becomes dependent on alcohol, we find that there are two other factors to be considered. These are the constituents of what we call addiction; the increase in tolerance for the drug and the evidence for physical dependence. Without concerning ourselves with the complex physiological aspects of this phenomenon, it must be apparent that as increasing doses of the drug are required for the satisfaction of the individual for whatever reason his whole living pattern must be distorted in order to fit in time, amount, and expense of his changing drinking pattern. The awareness too of unpleasant symptoms on removal of the drug can re-inforce any belief of need for alcohol and, one can assume that many late discomforts of sobriety are frequently interpreted as a craving for alcohol when in fact they merely represent the creakings of a

somewhat worn out mechanism trying to get along without its former ineffectual lubrication.

One interesting area to be considered here from a psychological point of view, although a narrow one to be sure, is that of the general time perception of the individual once he is enmeshed in the habituation process of alcoholism. This is well put forth by Gliedman (19), who describes the alcoholic as living constantly in an expanded present in which he is incapable of recalling adequately his past experiences in proper sequence or in sufficient order to be utilizable for him. He is under the pressure of the demands of the moment and is unable to devote himself to planning for his own future systematically. Such a concept helps us to understand to some extent the inconsistencies, the unkept promises, the seeming untruths, and many other incomprehensible bits of behaviour. Not answered, of course, in this concept is whether these characteristics were present initially and in sufficient degree to encourage alcoholism to supervene or whether they merely represent the distortions of a personality caught up in a habitual train of response, which then must be sustained and guarded at all costs; where alcohol has assumed an importance which places great demands on the individual's resources at any one moment in time, so that he is incapable of considering his past or his future adequately.

What happens then is that as each individual, for whatever reason, becomes more and more dependent on the use of alcohol, (and this is combined with certain behavioural qualities related to drinking itself, as well as the physical effects on the person) there tends to be, more and more, a sameness in the manifestations of the late characteristics of the illness and even though these are intermixed with the basic personality of the individual, we may come to feel that all alcoholics have certain kinds of behaviour patterns. The big danger, of course, is that we may leap to the conclusion that these have been constantly a characteristic of that personality and were part of the reason for his drinking, rather than being merely the product.

Physiological evidence to account for some of the characteristics of addiction is suggested in work recently reported by Olds (20). Apparently when certain cell systems in the midbrain of the rat are stimulated even in a painful way, through the use of implanted electrodes, the animal seeks the stimulus over and over again. Such observations arouse considerable speculation as to explanation for the more complex punishing experiences suffered over and over again by those who are addicted to the use of alcohol and other drugs.

One part of the late stage of this illness that is of interest from a psychodynamic point of view, is the syndrome, delirium tremens. In this we see a set of unexplained psychic phenomena which are undoubtedly related to some degree of change in metabolites consequent on prolonged assault with alcohol or nutritional depletion. Attempts have been made to relate this to certain single or group chemical deficiencies such as magnesium (21). The individual finds himself experiencing a series of vivid hallucinatory experiences which often, like dreams, tend to realize his fears as in the case of biting animals, (presumably threatening castration) or animals seemingly representing some other sexual symbolism equally fearful or abhorrent to the victim; on some occasions, less commonly, wishes are fulfilled when a person finds himself or herself in some kind of idyllic or peaceful surroundings with pleasant music. In many instances, the disease itself is lived through in microcosm since at the beginning of the hallucinations often the phenomena are only of mild interest or even hold some attraction to the victim, yet as the hours go by, they assume more terrifying, threatening and destructive proportions for him. Here is an area of psychopatho-

logy worthy of more study than has been granted to date.

Organic Complications

It is reasonable to consider for a moment the implications of organic deterioration. There have been well described syndromes for many years in which permanently disturbed mental states were recognized with characteristic evidences of brain deterioration. Now this is a most complex field since there seems to be ample evidence that these very grossly disturbed syndromes such as those described by Korsakoff or Wernicke, appear in a relatively small percentage of the very heavy drinkers. In fact, it is extremely difficult, both pathologically and clinically, to recognize intermediate stages which one would expect if this were the outcome of the alcoholic process alone. There is the possibility that alcohol is merely an accelerator in individuals who might in any case, be subject to pre-senile dementias or who, in the course of their drinking careers, find themselves frequently involved in situations where they receive mild to severe head injuries.

Nevertheless, we should continue to speculate and hypothesize on the existence of a pre-clinical degree of brain impairment not yet recognizable with our present diagnostic tools. Such impairment would account for milder degrees of the kind of problems we encounter in such a clear-cut way with advanced states of deterioration. These would be the difficulties in learning or conversely, ease of forgetting, and inability to organize material perceived as well as lessened control of emotional reaction (22). If we think for a moment, we will recognize that possibly these are characteristics of various patients who have difficulty carrying through with treatment. They seem unable to grasp the implications of their behaviour, they are unable to follow through with a program which has been organized for their management. Emotional explosions are common and frequently interrupt the course and continuance of their treatment. This is speculative, but worthy of our investigation.

Implications for Treatment

The traditional forms of psychotherapy or psychoanalysis, seem to have only limited application with the alcoholic and apply most readily to those fairly clear-cut psychoneurotic disorders where alcohol as yet is being used in a fairly symptomatic way of leaving the way open for the ordinary psychotherapeutic management of the situation. As the person moves on in his dependence and habituation or when the habituation has arisen out of fairly severe character disorder or in those instances where the habituation evolves from the social background rather than from an over-riding psychodynamic problem, or where deterioration is already taking place, then we must look to other methods. Logically, we must give the person every opportunity possible to make a physical recovery from the effects of his long alcoholic assault. We must offer the kind of support and encouragement that is going to be useful to the person; that is going to sustain him until such time as his dependence has changed and new habit patterns have been established and he is ready to begin exploring hopefully the insights of which he is capable. In this, of course, we must depend a great deal on the assistance of many others besides those who practice formal psychotherapy; the social worker, the nurse on the ward, the general physician, the clergyman and the alcoholic himself through encouragement and participating in groups with other alcoholics, whether in A.A. or in the clinic.

The Goals of Therapy

The goals can often be fairly simple. First of all, we recognize the deteriorating effect of prolonged alcoholic dependence; secondly, there is value in solving problems through dependence

on human agencies rather than on any drug, notably ethyl alcohol. Thirdly, to recognize that sobriety alone is not enough and that in order to stabilize it there must be a real change in dependence with a re-definition of goals. At the same time, the goals must be realistic and capable of being achieved by the individual concerned.

References

(1) Armstrong, J. D. The Search for the Alcoholic Personality, Annals of The American Academy of Political and Social Science, Vol. 315, pp. 40-47; January, 1958.

(2) Quaranta, J. V. Alcoholism: Study of Emotional Maturity and Homosexuality as Related Factors in Compulsive Drinking; Fordham Univ. Thesis (New York, 1947).

(3) Syme, Leonard. Personality Characteristics of the Alcoholic: Quart. J. Stud. Alc., Vol. XVIII, 1957, pp. 288-301.

(4) Chafetz, Morris E. Psychotherapy of Alcoholism: Quart. J. Stud. Alc., Vol. XX, No. 2, pp. 281, 1959.

(5) Freud, S.—Three Contributions of the Theory of Sex. 4th Ed. Washington, D.C.; Nervous & Mental Disease Publishing House; 1930.
—Contributions to the Psychology of Love. The most prevalent form of degradation in erotic life. (1912) In: Collected Papers: Vol. 4, pp. 152-216. London: Hogarth; 1925.
—Mourning and Melancholia. (1917) Collected Papers; Vol. 4, pp. 152-170. London; Hogarth; 1925.

(6) Brill, A. A. Alcohol and the Individual. N.Y. Med. J. 109: 928-950, 1919.

(7) Jones, E. Papers on Psychoneurosis. Baltimore; Ward & Co.; 1938.

(8) Glover, E. The Etiology of Drug Addiction. Int. J. Psycho-Anal. 13: 298-328, 1932.

(9) Sachs, H. The Genesis of Perversions. Abstract in: Psychoanal. Rev. 16: 74, 1929.

(10) Rado, S. The Psychoanalysis of Pharmacothymia. Psychoanal. Quart. 2: pp. 1-23, 1933.

(11) Menninger, K. A. Man against Himself. New York; Harcourt, Brace: 1938.

(12) Tiebout, H. M. The Role of Psychiatry in the field of Alcoholism. With comment on the concept of alcoholism as symptom and as disease. Quart. J. Stud. Alc., 12: pp. 52-57, 1951.

(13) Knight, R. P. The Psychodynamics of Chronic Alcoholism. J. Nervous & Mental Dis. 86: pp. 538-548. 1937.

(14) Levy, Robert I. The Psychodynamic Functions of Alcohol. Quart. J. Stud. Alc., Vol. 19: No. 4: p. 649; December, 1958.

(15) Cleckley, Hervey. The Mask of Sanity; C. V. Mosby Co., St. Louis; 3rd Ed. 1955.

(16) Abraham, Karl. The Psychological Relations Between Sexuality and Alcoholism. Int. J. Psychoanal. 7: 2, 1926.

(17) Suttie, Ian. The Origins of Love and Hate; Julian Press, New York; 1952.

(18) Navratil, L. Alcoholism and Birth Rate on the Problem of the Constitution of the Last Child—abstract—Quart. J. Stud. Alc., Vol. XVII, p. 517; September, 1957.

(19) Gliedman, Lester H. Temporal Orientation and Alcoholism; Alcoholism; April, 1956.

(20) Olds, James. Self Stimulation of The Brain; Its Use to Study Local Effects of Hunger, Sex, and Drugs. Science: Vol. 127, No. 3294, February, 9158.

(21) Krystal, H. Amer. J. Psychiat. p.p. 116; 137, August 1959.

(22) Talland, G. A. Psychological Studies of Korsakoff's Psychosis; Journal Nervous & Mental Dis. 127: 197, September, 1958.

Résumé

Il n'existe pas de type bien précis ou généralement reconnu de personnalité qu'on pourrait désigner du nom d'alcoolique. De nombreuses théories ont été formulées touchant certains particuliers aux prises avec des problèmes de ce genre. Ainsi on a parlé de vives impressions orales durant l'enfance avec évasion dans l'ivresse afin de réaliser un changement d'humeur (Freud) de fuite des impulsions homosexuelles, des pensées incestueuses ou d'un sentiment de culpabilité découlant de la masturbation (Brill), d'un compromis entre les névroses compulsives et les névroses hystériques (Sachs), d'un problème de dépression où l'alcool sert à produire l'exaltation (Rado), d'un mécanisme d'auto-destruction (Menninger). Ces auteurs et bien d'autres ont parlé de personnes qui trouvaient dans l'alcool un moyen commode d'exprimer leurs problèmes de personnalité particuliers. L'alcool procure à bien des gens une satisfaction unique en son genre, un sentiment d'accomplissement; pour un grand nombre, d'autre part, l'existence, pour

des raisons personnelles, d'antécédents et de milieu, est remplie d'ennui, de frustrations et de désappointements.

Beaucoup de personnes voient dans l'alcoolisme une expression d'homosexualité latente. Cependant, il se peut que l'on confonde le refoulement des instincts sexuels ou émotifs de diverses sortes qui sont le produit des actes culturels d'un particulier. Si l'on généralise, ce qui est inacceptable dans son propre comportement sexuel, à quelque niveau que ce soit, ouvertement ou passivement, peut porter à faire de l'ivrognerie une perversion en elle-même, une substitution complète à tout mode d'expression sexuelle.

Il faut examiner la question de l'alcoolisme dans le contexte de la société dont l'individu fait partie, et selon le degré auquel cette habitude permet l'absorption de grandes quantités d'alcool ou incite à cette absorption. Le fait que cette substance procure un certain plaisir et une certaine satisfaction peut conduire à son usage répété, peut inciter à explorer jusqu'à un degré dangereux même en l'absence de trouble sérieux de la personnalité. D'autre part, si l'acceptation continue de l'alcool est faible, une dépendance anormale peut ne se manifester que lorsqu'il y a déjà un trouble sérieux de la personnalité.

On peut, naturellement, voir dans l'alcoolisme une manifestation de n'importe quels syndromes psychiatriques. Bien que de tels syndromes soient le plus souvent une psychonévrose ou un trouble du caractère, la dépression est fréquente; cependant, les psychoses schizophréniques et organiques sont relativement peu communes.

On reconnaît qu'il pourrait bien y avoir des altérations du métabolisme ou même des défauts constitutionnels qui mèneraient à une dépendance croissante. Des expériences comme celles d'olds, sur l'auto-stimulation répétée et douloureuse chez les animaux, expliqueraient les sentiments complexes à répétition de châtiment qu'éprouvent ceux qui s'adonnent à l'alcool.

Le delirium tremens justifie de plus amples investigations du double point de vue physiologique et psychologique. Et ce qui importe peut-être encore plus, c'est l'impossibilité où nous trouvons de reconnaître assez tôt l'avarie cérébrale qui produit l'incapacité de fournir un plein rendement physique et mental, mais où il est impossible de poser le diagnostic d'un syndrome bien déterminé.

Pour ce qui est du traitement, il semble que la psychothérapie et la psychanalyse conventionnelles n'aient que des applications limitées chez l'alcoolique. En plusieurs cas, l'habitude depuis longtemps acquise, la détérioration précoce, ou le trouble sous-jacent de la personnalité laissent voir la nécessité d'un appui et d'un encouragement prolongés longtemps après que le premier épisode aigu a pris fin. Il faut les efforts réunis du médecin, du psychiatre, du travailleur social, de l'infirmière, et peut-être encore davantage, ceux d'autres alcooliques, soit dans un milieu clinique, soit au sein de la société *Alcoolics Anonymous.*

Pour traiter le malade, il nous faudra viser à lui faire reconnaître l'effet de détérioration de sa dépendance prolongée sur l'alcool; obtenir qu'il essaie de régler ses problèmes en s'adressant à des êtres humains plutôt qu'à une drogue; qu'il reconnaisse que la sobriété seule ne suffit pas mais doit s'accompagner d'un changement de dépendance et de l'acquisition de nouveaux idéaux. Nous devons aider le malade à se tracer une voie qu'il est capable de parcourir.

OBSERVATIONS ON THE ACTION OF SERNYL — A NEW PSYCHOTROPIC DRUG

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It is possible to divide psychoactive drugs into psychotomimetic, inhibitory and excitatory agents(7). Psychotomimetics or hallucinogens are those chemicals which cause a transitory psychotic-like state or "model psychosis" through dissociation of the usual association pathways. Drugs that produce inhibition are the well known older sedatives and the whole group of new tranquilizing, neuroleptic or ataractic agents. Many of this group have physiological depressant actions of varying degree. Drugs that produce excitation are those central stimulants which produce increased alertness, increased speed of reaction, promote wakefulness and reduce the subjective sensation of fatigue(6). An entirely new group of psychoactive drugs are the anti-depressant substances. Most of the recent phenotropic drugs belong to one of these groups, while Sernyl (CI 395), a relatively new compound of Parke, Davis & Company, does not fit into any of the above four categories since it may exhibit different characteristics at different dose levels.

Pharmacological and Clinical Data

1-(1-Phenylcyclohexyl) piperidine monohydrochloride (Sernyl) is a white, stable, glistening, solid chemical with a melting point of 234-236°C, soluble in water and ethanol. It immobilizes animals, produces a marked blocking of all sensory stimuli, causes no adrenergic or ganglionic blocking and shows no anticholinergic or anti-histaminic action.

The first clinical application of Sernyl was made by Greifenstein and associates when they introduced it as an intravenously administered anesthetic agent. Given in an 0.1% solution by continuous infusion at a rate of approximately 5 cc/min. in a dose of 0.25 mg/kg body weight, the infusion brought about a complete analgesia after 8-11 mgms. of the drug had been given. At this point a slight increase in the minute volume of respiration and a consistent and significant rise in both systolic and diastolic blood pressure were observed as well as a slight increase of the pulse rate. Postoperatively, 10 out of 64 cases exhibited severe degrees of manic behaviour and a number of the remaining group appeared to be euphoric and disoriented as if intoxicated. It was also observed by the same authors that larger doses of the drug, 0.5-1.0 mgm/kg of body weight, produced a state of agitation, and still larger doses, convulsive seizures (5). Because laboratory observations indicated that phenicyclidine possesses central nervous system depressant properties associated with an improvement of mood, investigations were also carried out along this line.

Bodi and his associates noted improvement in 25 of their 32 psychiatric patients. According to these authors, Sernyl appeared to be most effective when given to patients with anxiety symptoms in mild to moderately severe degree, but was less effective in patients with personality disorders or with residual schizophrenic symptoms(1).

Luby et al. described the sensory and cognitive deviations produced by the drug and compared them with schizophrenic symptomatology. They introduced the term schizophreno-mimetic and applied it to Sernyl. These workers gave 0.1 mgm/kg in 150 cc of 5% dextrose administered over a period of 12 minutes. Psychological and neurological changes were observed and the former

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were grouped under the headings of body image changes, estrangement, disorganization of thought, negativism and hostility, drowsiness and apathy, hypnagogic state, feelings of inebriation and repetitive motor behaviour (10).

Review of Literature

The possible use of intravenous Sernyl in psychiatry extends to three areas: 1) to control excited patients, having an advantage over barbiturates in that it does not depress blood pressure and respiratory rate, 2) as a diagnostic test for schizophrenia, since schizophrenics seem to be most susceptible to this drug, and 3) as an abreactive agent(15). In regard to the second possibility Luby and his collaborators on the basis of their studies, conclude that the model psychosis produced by Sernyl, as well as certain primary symptoms of schizophrenia, may have their basis in a dysynchrony or defect in proprioceptive feedback. According to these authors "this hypothesis is a tentative one and it is understandable that other meaningful hypotheses regarding the action of Sernyl and the pathophysiology of schizophrenia may be postulated" (10). This hypothesis was based on the findings of severe disturbances in body image, affect, attention and thinking, essentially the primary symptoms of schizophrenia. Further studies along these lines were carried out by Rosenbaum and associates, who found that in contrast to LSD 25 and amobarbital, Sernyl produces disturbances in attention, motor function and proprioception, approaching the deficit level shown by schizophrenics. It was concluded by the same authors that Sernyl administration results in schizophrenia-like impairments of primary attention and motor function, whereas LSD 25 stimulates only the secondary symptoms. This was interpreted as evidence for the hypothesis that disturbance in proprioception may be the pathological mechanism mediating the impairments in performance and motivation found in schizophrenia and produced by Sernyl(12).

Experimental Procedure

The drug was administered to a group of 55 patients, 21 females and 34 males. All patients were chosen from the inpatient population of a mental hospital. The length of hospitalization varied from a few days up to many years. The mean age of subjects was 35.9 years with a range of 18-50. While all 55 sample members received varying dosages of Sernyl, 30 other drug interviews were conducted on six patients including LSD 25, Mescaline Sulfate, Sodium Amytal and Desoxyn HCl.

In all cases, patients on medication were only tested after a minimum of 72 hours without medication and in all cases pretest physical examinations indicated no intercurrent disease. The patients fell into the following diagnostic categories: 1) 43 schizophrenia, 2) 3 paranoid state, 3) 3 manic depressive psychosis, 4) 5 alcohol dependency and 5) 1 mental deficiency. The test drug Sernyl was administered intravenously as were all other test drugs, except for Mescaline SO_4 and LSD 25. Sernyl dosage ranged from 0.01 mgm/kg to a maximum dosage of 0.1 mgm/kg, except in one of the first cases, who received a dose of 0.12 mgms/kg. The time of administration ranged from 1 minute to 10 minutes. The test drug Sernyl was administered in the dilution recommended by the manufacturer, 0.1% and after completion of the test, patients were replaced on their usual medications. Only in three isolated cases was special sedation required within the post-test 24 hours.

The actual test period from the time of drug administration to the return of the patient to the ward varied from 4-8 hours. During this time, the patient remained in a single room, attended by two nurses or nursing attendants, one of them taking detailed notes with verbatim samples of the patients speech, the other charting regularly the patient's blood pressure, respiration and pulse rate as well as his physical activity. Some of the experiments were recorded on a record-

ing device. In most of the experiments the patients were given minimal pre-test instructions, but were encouraged to verbalize and express subjective changes.

Data accumulated were primarily of two orders: 1) objective—the observations of the psychiatrist and the nursing staff, neurological examinations and a series of psychomotor and perceptual test procedures 2) subjective—data obtained from the patient via introspection as well as projective data through the administration of a multiple choice Rorschach test. The psychophysiological tests used were those described by Lehmann and Knight (9) for the determination of basic perceptual functions, psychomotor discharge, capacity of recall, attention, concentration and learning(9). Critical flicker fusion frequency, after image disappearance level, tapping speed, reaction time, hand steadiness, digit span, digit symbol substitution, cancellation and spiral after effect were employed as a test battery(8). In addition a neuropsychiatric check list was used to compile observational data.

General Observations

1. The effects of varying dosage and time of administration were studied separately by: a) administering Sernyl in increasing concentration intravenously from 0.01-0.1 mgm/kg, b) decreasing the time of administration from 10-1 minute. It was noted that in low concentration the drug seemed to have a disinhibiting potential, but never to the extent seen with Sodium Amytal or other barbiturates.

On increasing the dose or decreasing the time of administration, the picture became increasingly dependent on and related to the subject's psychopathology. The intensity of reaction was in direct relationship to the amount of drug administered with individual variations depending on ego-strength and ego-defenses up to a critical value beyond which any further increase of dose or decrease of the time of administration resulted in an uniform inhibitory action. These general impressions led us to choose 0.07 mgms/kg as the standard dosage and seven minutes as the standard time of drug administration in our further studies.

2. The effects of Sernyl administration were compared to the reactions to Mescaline Sulfate and LSD 25. Our psychophysiological tests did not provide data which allowed for measurable differentiation between the different drug response patterns. It was felt by the authors that whereas the reactions to Mescaline and LSD 25 were the expected "drug or personality specific" manifestations, the total response pictures to Sernyl were to a greater degree "pathology specific". This is in accordance with the findings of Luby and his associates, who found that, while LSD 25 and Mescaline SO_4 "might be said to mimic the secondary or restitutional symptoms of schizophrenia" Sernyl "uniformly intensifies the primary symptoms of a small group of schizophrenic patients". It was our opinion that the Sernyl reactions we noted in our cases were "pathology specific" both as to form and content.

Physiological Findings

Sernyl was originally employed as an anaesthetic agent and previous investigators have reported anaesthesia and hypaesthesia as occurring consistently in the human (5) (10). Decrease of sensory discrimination of varying degree, as well as paraesthesia, were consistent findings in our study. Deep reflexes i.e. biceps, triceps, knee, ankle jerks, were uniformly increased, but not necessarily in proportion to the dosage. Nystagmus was present in less than 10% of our cases and while all patients complained of vertigo, of unsteady and slapping gait and swaying, repeated testing of cerebellar function did not establish a specific or consistent response pattern.

In regard to the autonomic nervous system, nausea occurred in 90% of our cases either during administration or within 30 minutes thereafter. This was

aggravated by activity, especially, if the patient was asked to stand up. Approximately one half of our patients vomited and, in two cases, there was fecal incontinence. The latter occurred in moderately deteriorated schizophrenics. Ten percent of the patients complained of a dry mouth and thirst. A uniform elevation of the systolic blood pressure was noted, the mean elevation being 10-20 mm/HG with the maximum rise occurring within 30-45 minutes after Sernyl administration and then subsiding slowly within 2 hours. A rise in the pulse rate was associated with the blood pressure elevation. In a number of patients fluctuation of blood pressure and pulse was observed, but in our series hypotension did not develop to the degree of producing syncope. We were prepared to deal with respiratory system emergencies, but these did not occur in our material. Twenty percent of our cases showed a slight increase in respiratory rate.

Psychological Testing

Psychophysiological testing and multiple choice Rorschach was administered. Thirty per cent of the subjects were unable to complete the full battery. All data were tabulated for purposes of comparison, but no significant or internally consistent response pattern was apparent in those areas of functioning for which the tests used were accepted as valid. The one exception was lengthened simple reaction time. It was noted that in 3 alcohol-dependent patients a decreased reaction time occurred with an increased tapping speed while critical flicker fusion frequency and after-image-disappearance-level were diminished.

Behavioural Observations

All patients were known to the interviewers previous to the drug experiments and psychopathology, character traits and ward behaviour were known to us on the basis of daily observation of behaviour on the ward. In every case it was evident that a patient given intravenous Sernyl was undergoing a maximal stress situation in terms of threat to the total self-organization. This personality disorganization was most evident at the dose level we had chosen for our final testing (0.07 mgm/kg in seven minutes) and was particularly dramatic and striking in patients who had recently recovered from acute schizophrenic episodes. Within ½ hour after drug administration, the intensity of reaction was at its maximum, subsiding within 3-4 hours, residual anxiety and apprehension lasting for 8-12 hours. In order of frequency the occurrence of disorientation, emotional outbursts of rage or sorrow with weeping and erratic behaviour were observed. Varying degrees of anxiety, restlessness and tenseness to the point of panic were apparent in 41 of our cases. Only 3 patients became euphoric, laughed with inappropriate affect or expressed evidence of pleasure during the Sernyl experience. Patients manifested suspiciousness in cases where projective mechanisms were a significant feature of the psychopathology. Most prevalent was an expression of fearful expectancy, puzzlement and foreboding of disaster with a pathetic turning to the observer for reassurance and relief.

It was of particular interest to note that in 2 cases, there was a gradual observable emergence of the original acute psychotic state. Both these cases were young females and both had been diagnosed as paranoid schizophrenia. This was most clearly seen in a patient, who some months prior to the Sernyl experience had been floridly psychotic, with visual and auditory hallucinations. At the onset of the interview, she was appropriate, talkative and friendly. Following Sernyl administration she became progressively more restless, silent, suspicious, first of faint noises outside the interview room and then of her immediate environment and of persons present. Within 3 hours, she was withdrawn, silent and overtly hallucinating. The re-activated psychotic state lasted for 3 days, then she responded to Phenothiazine therapy and rapidly returned to her pre-Sernyl

level of integration. In interviews later on she was able to discuss with lucidity and some insight her disturbed state.

Subjective Material

1. The Sernyl experience was uniformly described as unpleasant and extremely frightening on later questioning. It was a common occurence for the patients to spontaneously request that they never be exposed to such an experience again. The experiential nature of the internal phenomena consequent to Sernyl administration was evidently of ego-alien quality. This was particularly noted in patients who had undergone LSD 25 and Mescaline experiences as well. Such patients recalled and distinguished clearly the frightening nature of the drug reaction on a certain test day. Invariably, the drug referred to by these patients was Sernyl. Patients, trembling with terror, would repeatedly ask "where am I?, what is happening to me?, something is happening, I feel terrible", etc, but content was invariably absent. During these states, patients would turn to staff with pleas for assistance and relief from this state of nameless and undefined apprehension.

2. Preoccupation with death was a common finding. This took various forms: expressing fear of death "I don't want to die", requesting reassurance that death was not imminent or re-statements of desire to live, ambivalence about living or dying or the expressed desire to die. In one of these cases referred to above as re-experiencing a previous psychotic state, resignation and acceptance of impending death was presented dramatically. This was coupled with a deeply personal re-evaluation of her past and with questioning of the nature of her personal existence in a dramatic manner, e.g.: "I suppose my mother had me–I don't know–I did not ask her to have me –I didn't want to be born" and "please kill me, be a good man and kill me, kill me please, I want to die. I don't want to live any longer–I didn't want to be born –it was an accident" and "no wonder, I am insane–I am free–I feel free as a breeze–you can throw me in the river". Sandison and associates (1954) refer to the intense reliving of repressed personal memories during the LSD 25 experience as "the surging up of repressed experiences" and Stocking (1940) in speaking of the Mescaline psychosis refers to this phenomenon as "a tremendous volcanic eruption of the subconscious with the repressing force in complete abeyance" (14)(15). Observations made on our patients would indicate that Sernyl administered in certain doses may have similar potentialities for reviving repressed significant events and affects, with the implied therapeutic possibilities.

3. Body image disturbances occurred in the majority of our cases, usually associated with unreality feelings. Many patients spoke of feeling weightless, e.g. "floating on top of the world" and "like a feather". These sensations did not appear to be alarming. Disturbances of the body image were in reference to the whole body rather than to discrete body parts, e.g. "I am a baby", "now I don't know what to do, I am a little boy of 3 years". Feelings of estrangement from the immediate environment were frequent, patients freely expressing their puzzlement that people and things about them had changed their expression, had become "a different world". It was of interest that certain aspects of the patients' personality appeared to be observing the whole procedure and to be able to relate to the interviewer even during maximal stress.

Site of Action

1.) Clinical and Neurological Evidence.

The site of action of Sernyl in the central nervous system is not yet defined. According to the clinical observations made by Meyer, Greifenstein and De Vault the thalamus and mid brain are involved. This is based on the demonstrable impairment of pain, touch, proprioception and discrimination and the observation that large doses produce ataxia, rotatory nystagmus, bilateral ptosis

(10) and suppression of the pupillary light reflexes. The increase of blood pressure may also be an indication of this(5).

2.) Pathological Evidence.

No characteristic brain pathology has been observed in animals following Sernyl administration(1).

3.) Electroencephalographic Evidence.

a.) The effect on the cortical EEG of Macaca mulatta monkeys was dependent on dosage. The effects varied in direct proportion to dosage from minimal or no change, to medium voltage, fast waves, or high voltage delta activity. Photic driving responses were decreased in amplitude(10).

b.) On human subjects the EEG showed some slowing, most pronounced in theta activity and a decrease in fast activity after the infusion of 2-3 mgms. of the drug(5). According to recent literature, the result obtained after a large dose (0.2 mgms/kg) is marked theta activity, after a medium dose (0.1 mgm/kg) slowing in the 5-8 c/sec. frequency range and after a minimal dose (0.03 mgm/kg) a slight theta slowing or no apparent change. It was also pointed out by Rodin and associates that the psychotomimetic effects (severe depersonalization, feeling of unreality, thought defect characterized by concreteness and looseness of association, hypnagogic states, repetitive motor phenomena and feeling of inebriation) were observed also in the absence of definitive EEG changes. (1, 11, 16). On the basis of the EEG changes reported, site and mode of Sernyl action must still be considered obscure.

"Meditatio mortis"

We have already referred to the remarkable preoccupation with death and dying apparent in our test subjects. This phenomenon attracted our particular attention and the literature was consulted. Morgagni is said to have referred to the fear of dying as angor molestus and Seneca's physician employed the term meditatio mortis, presumably in reference to thoughts on impeding death. Gowers (1907) noted the frequency with which this phenomenon occurred in association with vagal and vasovagal attacks(4). This observation has been made earlier by Nothnagel describing it as "angina vasomotoria" and by Bonnier referring to (1904) "Syndromes medullaires" (2) Gowers described vagal attacks as recurrent seizures of sudden onset, usually without loss of consciousness, the symptoms being mostly sensory and subjective. Subjective symptoms were those of gastric, respiratory and cardiac discomfort associated with a sense of impending death. Clinical cases were presented by this author, but the etiology was not clarified. The following description is given: "With the dyspnoic or the cardiac sensation or both is often associated a sense of impending death, so intense that no recollection of its falsity in preceding attacks prevents the conviction of its present reality"(4).

Sensations of dying in association with vagal attacks were reported by Ryle. He uses the term angor animi and notes that this sensation has been reported in labyrinthine vertigo, tumors invading the vagus nerve and also in cerebral tumors. In attempting to explain this subjective symptom, he states "it must surely be a powerful medullary stimulus of some kind", and further uses the term "medullary storm". He views angor animi as "the aura of a nervous storm having its origin in those medullary centres upon which the act of living depends". At the date of writing (1928) Ryle could not refer to the reticular activating system, since the latter's functional activity and importance was not then known(13).

David and associates (1946) reported that manipulation of the medulla oblongata produced a sudden sense of dying, the patient stating: "I am going to die" (3). Cairns (1952) noted that following accidental needle puncture of the medulla oblongata, the patient lost consciousness and later said: "I wish I had been quite killed." This author refers to the sense

of dying as being one of "symptoms, related to bulbar lesions which seem primarily disturbances of vital forces, breathing, heart beat, body awareness and of being alive"(2). The above observations would indicate that the lower brain stem must be considered as a possible area of investigation in regard to the site of action of Sernyl.

Summary

Sernyl was administered to 55 patients, chosen at random from the population of a mental hospital.

Its disinhibiting potential appears to be related to the dose. Sernyl in doses of 0.07 mgms/kg administered in 7 minutes by the intravenous route activated the patients specific psychopathology to a greater degree than known psychotomimetics (LSD 25 and Mescaline Sulfate). Physiological and neurological observations, psychological tests and behavioural observations were made and correlated with the collection of subjective data. The unpleasant and extremely frightening nature of the experience, the preoccupation with death and body image disturbances were the most characteristic features observed. The history of the feeling of impending death as a symptom ("meditatio mortis") has been reviewed and it is suggested that the lower brain stem may be considered as a possible site of action.

Judging from our findings, Sernyl would not appear to be a psychotomimetic or schizophrenomimetic drug in the true sense, although certain aspects of the response picture obtained in psychiatric patients resemble the primary symptoms of schizophrenia. The drug seems to possess no particular therapeutic value, at least not at the present state of our knowledge.

We are indebted to Drs. H. Ast, L. Douyon, F. Kristof, for their valuable assistance in these observations.

We are indebted to Dr. C. Sterlin for assistance in these observations and particularly for preparing a resumé in the French language.

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References

(1) Bodi, T., Share, I., Levy, H. and Moyer, J. H. The Clinical Trial of Phenycylidine (Sernyl) in Patients with Psychoneurosis. Antibiotic Medicine and Clinical Therapy, 6, February, 1959.

(2) Cairns, H. Brain, 75, part 3, 1952.

(3) David, M., Talairach, J., and Hecaen, H. Annual Medical Psychology 1, I, 1946.

(4) Gowers, W. R. The Borderline of Epilepsy, London, Churchill, 1907.

(5) Greifenstein, F. E., De Vault, M., Yoshitake, J., Gajewski, E. A Study of 1-arylcyclohexylamine for Anesthesia, Anesth, and Analgesia, 37, 283-94, 1958.

(6) Leake, Chauncey D. Introductory note to Himwich, Harold E., ed., Tranquilizing Drugs, American Association for the Advancement of Science, Washington, 1957.

(7) Lehmann, H. E. Concepts, Rationale, and Research, in Psychopharmacology Frontiers, ed. by N. S. Kline, Boston, Little Brown 1959, p. 21-30.

(8) Lehmann, H. E., and Czank, J. Differential Screening of Phenotropic Agents in Man, J. Clin. & Exper. Psychopath. 18, 222-235, 1957.

(9) Lehmann, H. E. and Knight, D. A. Psychophysiologic Testing with a new Phenotropic Drug, Trifluoperazine. Philadelphia, Lea and Febiger, 1958, p. 34.

(10) Luby, E. D., Cohen, B. D., Rosenbaum, G., Gottlieb, J. S., Kelley, R. Study of a New Schizophrenomimetic Drug—Sernyl. A.M.A. Arch. Neurol, & Psychiat. 81, 363-369, 1959.

(11) Rodin, E. A., Luby, E. D., Meyer, J. S. EEG Findings Associated with Sernyl Infusion. Electroencephalog. and Clin. Neurophysiol. 11, 796, 1958.

(12) Rosenbaum, G., Cohen, D. B., Lubby, D. E., Gottlieb, J. S., Yelen, D. Comparison of Sernyl with other drugs, A.M.A. Arch. General Psychiat. 1, 651-657, 1959.

(13) Ryle, J. A. Guy's Hospital Report. London, 78, 371, 1928.

(14) Sandison, R. A., Spencer, A. M. and Whitelaw, J. D. A. The Therapeutic Value of LSD 25 in Mental Illness. J. Ment. Sc. 100, 491, 1954.

(15) Stockings, G. T. Clinical Study of Mescaline Psychosis with Special Reference to Mechanism of Genesis of Schizophrenic and other Psychotic States, J. Ment. Sc. 86, 29-47, 1940.

Résumé

Du Sernyl (1.–Phenylcyclohexyl) piperidine monohydrochloride) fut administré à 55 sujets choisis au hazard parmi les patients d'un hôpital mental.

L'effet disinhibiteur du produit dépend essentiellement de la dose utilisée. Administré par voie i.v. à raison de 0.07 mg/kg de poids corporel (injection lente étalée sur 7 minutes), le Sernyl jouit de la propriété d'activer la psychopathologie spécifique des patients à un plus haut degré que les psychotomimetiques connus (LSD 25 et sulfate de Mescaline). L'administration de ces derniers, en effet, produit un tableau spécifique de la drogue administrée, alors que la symptomatologie déclanchée par le Sernyl serait plus spécifique de la pathologie du patient.

L'évaluation de l'action du produit est basée sur les réactions physiologiques et neurologiques, les données des tests psychologiques, l'observation du comportement de nos patients, et nous avons confronté le tout avec les phénomenes subjectifs qu'ils nous rapportaient.–Le caractére pénible et effrayant de l'expérience, la hantise de la mort, ("meditatio mortis") et les altérations du schéma corporel dans son ensemble furent les plus caractéristiques des phénomènes subjectifs observés.

En ce qui a trait au lieu d'action du Sernyl, nous présentons d'abord ici une brève revue de la littérature relative au "sentiment de la mort imminante" au tant que symptôme localisateur. Bien que les indications fournies par les examens electroencephalographiques et anatomopathologiques soient essentiellement nonspecifiques, nos observations sur le plan psychiatrique nous portent à considerer la partie inferieure du tronc cérébral comme lieu d'action possible du Sernyl.

Par ailleurs, il ne nous semble pas que le Sernyl puisse être considéré comme un psychotomimetique ou un schizo-phrénomimetique au vrai sens du terme, bien qu'il produise chez le malade mental un tableau rappelant dans une certaine mesure les symptômes primaires de la schizophrénie.–Ajoutons enfin que ce produit ne nous semble posséder aucune valeur thérapeutique particulière, du moins dans l'état actuel de nos connaissances.

RE-EVALUATION OF AN ACTIVITY TREATMENT PROGRAMME WITH REGRESSED SCHIZOPHRENIC PATIENTS*

MORRIS M. SCHNORE, PH.D.[1]

In a previous article in this Journal Henderson (5) reported a study of psychological changes in a group of seriously regressed male schizophrenic patients during one year of an activity treatment program. The program consisted of intensive social, recreational, and occupational activities. Lately, similar treatment programs have been referred to as "total push" therapy (3). Although medical treatment was continued, as indicated, the patients did not receive psychotherapy by trained personnel.

This study is a further evaluation and follow-up of the original group of patients, one year after the previous report (5) or two years after the beginning of treatment. The main reason for re-evaluation was the fact that the original program was terminated after the patients had been on the treatment for one year and four months. At that time, the patients were transferred to a much larger ward which had a total patient population of 80. The activity program was continued, very similar in nature to the original program which has been described (5). However, while on the original ward there was one staff member (physio-therapist, attendants, occupational therapists, and music therapists) per 3.6 patients, on the new ward the ratio was 1:8. Thus, because the new environment was different physically and socially, and the patients received less individual attention, it was decided to investigate whether the patients had maintained the improvement which was noted one year ago. Kamman et al. (6) have reported that one year after a six-months participation in an activity program, similar to the one at this hospital, patients showed regression, female subjects regressing to their pre-program level. Furthermore, because the subjective impressions of the staff were that, in spite of the drastic changes in the surroundings, the patients had continued to improve, it was planned to specify the psychological changes in more detail.

*This study was conducted at the Ontario Hospital, St. Thomas. The author wishes to thank Dr. C. A. Cleland, Superintendent of the Hospital and Dr. W. Babiak who is presently in charge of the activity program, for their support of this study.

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Method

Subjects

Of the 18 patients who constituted the original experimental group, four patients had been removed from the activity treatment ward because of their disturbed behaviour. Thus, the present experimental group consisted of 14 patients. They were all chronic male schizophrenics.

The matched control group consisted of 10 patients (originally there were 14 patients) three had been transferred to the enlarged activity treatment program and one had left hospital on probation. The latter patient had received individual attention from one of the staff music therapists for about a year before leaving the hospital. The groups were matched on chronological age, education, age on first admission, and number of years since first admission. A comparison of the experimental and control group with respect to the matching variables is presented in Table I. It can be seen that on these variables the groups, in spite of the drop-outs, are matched quite closely.

Assessment Techniques

With one exception, the "Minimal Social Behavior Scale" (MSBS) (4), all those tests were administered, on which one year ago the experimental group had shown significantly greater changes than the control group. The MSBS was not administered because, a year ago, the

TABLE I—MEDIANS AND RANGES OF MATCHING VARIABLES FOR EXPERIMENTAL AND CONTROL GROUPS

Matching Variable	Experimental Group N = 14		Control Group N = 10	
	Median	Range	Median	Range
Age in years	46.5	27–52	47.5	30–50
Education	8	7–17	8	6–15
Age on first admission	25.5	17–35	26	18–37
Years since first admission	19	10–25	16	11–26

patients of the experimental group had obtained scores close to the maximum score possible on this scale. The assessment battery therefore consisted of: (A) a short form of the Wechsler-Bellevue Intelligence Scale, Form I, (Vocabulary, Information, Block Design, and Similarities), (VIBS), (B) another intelligence test, the Draw-a-Person Test (DAP) which requires psychomotor skill, and (C) a modification (5) of the Lorr "Multidimensional Scale for Rating Psychiatric Patients", (MSRPP) (7). The latter assessment is based on ward behavior and yields an over-all adjustment score, the Morbidity Index (MI) and scores on 9 relatively independent aspects of behavior, such as "motor disturbance", and "conceptual disorganization".

Administration

The intelligence test – VIBS – was administered individually to both groups of patients in order to control for possible changes in scores due to practice (this being the fourth administration of the test). The test was administered in the standard manner by the staff psychologists of this hospital. To obtain a more detailed picture of possible changes the patients of the experimental group were also administered the other intelligence test – DAP and the MSRPP. The former was administered by the psychologists after the VIBS test and the latter was completed by two attendants who had received training in the use of the rating scale during the previous project.

Results

The medians and ranges of the test scores for the treatment group before and two years after treatment are presented in Table II.

Statistical comparison of changes using the Binominal Test (8) reveals that they are all statistically significant ($p < .05$). Thus, the improvement was evident on both intelligence tests, and there was also a decrease in severity of

TABLE II—MEDIANS AND RANGES OF THE TEST SCORES* BEFORE AND TWO YEARS AFTER TREATMENT

	Before		2 years		
	Median	Range	Median	Range	P
I.Q. (VIBS)	0	0–122	83.5	45–121	.01
DAP	0	0– 24	19.5	0– 30	.01
MSRPP–MI	42	12– 59	19	9– 56	.05

*Large scores are associated with little pathology, except on MSRPP where large scores indicate severe pathology.

symptoms as judged by the behavior on the ward. It is worth noting that the median I.Q. score for the treatment group one year ago was 67.5, as compared to the present median score of 83.5. This suggests not only retention of improvement exhibited previously but further improvement. This difference between the I.Q. scores obtained one year ago and those obtained presently is also statistically significant ($p < .01$). Because of repeated testing and possible improvement in scores due to practice, a further comparison of I.Q. scores was made between the *changes* in the treatment group and *changes* in the control group. This comparison, using the Mann-Whitney Test (8) reveals that the treatment group showed significantly ($p < .01$) greater increases than the control group.

To specify the psychological changes which had taken place over the two year treatment period several additional statistical analyses were performed. With respect to the intelligence test results (VIBS) a comparison was made between the weighted scores on the two subtests (Vocabulary and Information) which depend primarily on previously acquired habits and the two subtests (Similarities and Block Design) which require abstract ability. If the improvement were rather superficial one might have expected that the increase in the I.Q. scores was mainly due to recovery of previously established habits. The results do not support this hypothesis. At the present testing the weighted scores on the four subtests were not significantly different and there was no differential improvement among the subtests.

The analysis of the behavioral ratings (MSRPP) with respect to the 9 relatively independent sub-scales or dimensions of psychopathology reveal the following: Scores on 5 sub-scales, A-retarded depression vs. manic excitement, K-conceptual disorganization, F-perceptual distortion, G-motor disturbance, and B-resistiveness, showed statistically significant improvement. Scores on the following 4 sub-scales, E-agitation, I-withdrawal, D-activity level, and H-belligerence did not show any significant change. Thus, with respect to the emotional dimension, the treatment was accompanied by decrease in manic-like behavior, e.g., loudness of speech and frequent mood swings, and behavior associated with depression, e.g., barely audible speech and inhibition of feeling. However, no significant change was seen in behavior usually identified as indicating "depressive agitation", e.g., manifest tension and overconcern with health and bodily functioning. With respect to the classical symptoms of chronic schizophrenia, the treatment was accompanied by a decrease in muteness or irrelevant and incoherent speech, less evidence of visual and auditory hallucinations and a decrease in meaningless repetition of words and phrases as well as bizarre movements and postures. However, the patients still exhibited less than average interest in their surroundings and avoidance of others. Although the patients were much more cooperative than previously they were still somewhat underactive, exhibiting slowed movements and pathological submissiveness.

Qualitative Findings

It was noted earlier that from the daily observations of patients the ward staff felt that the activity treatment resulted in a general improvement of the patients' mental status. This observation is supported by the comparison of the number of the experimental as opposed to the control group patients who are steadily employed. While before treatment only one patient of the experimental group did some work on the ward, at present, 67 per cent of patients (12 out of the original 18 patients) are working. Eleven patients are employed at various jobs within hospital, e.g., laundry, kitchen, and one patient is working at a full-time job outside hospital. Several of these began work more

than a year ago. From the 10 patients in the control group, only one has started to work. It is evident that the qualitative data fully agree with the psychological test results.

Discussion

The results of this study clearly indicate the success and limitations of the "activity" treatment programs. On one hand, the original objectives of the program, namely to decrease the acute psychopathology in order to improve the ward adjustment of a group of seriously regressed male chronic schizophrenic patients appear to have been more than achieved. The patients have not only maintained their improvement, noted a year ago, but have shown further improvement, although they received less individual attention. It should be noted that the patients selected for the activity treatment were judged to be the most regressed patients from the 1000 (total) male population of this hospital. The severity of illness of the patients selected is underlined by the fact that it was impossible to find another group of patients in the hospital with equally severe pathology. In spite of this, the objective evaluation of changes associated with treatment revealed greatly improved intellectual functioning, both involving verbal and motor performance. The patients also exhibited a decrease in schizophrenic symptoms and their ward adjustment had significantly improved.

On the other hand, although several patients are doing productive work, none of them can be considered "cured" and their adjustment has not improved to the extent that discharge will be considered in the near future. To summarize, one might be very enthusiastic about the results of this activity program or only mildly so, depending on whether one focuses on the great improvement the patients have shown or on the considerable improvement still required before these people will be able to adjust to life outside the hospital.

The findings of this study also have some theoretical implications. Firstly, the results support the contention of those who claim that the progressive regression and deterioration, the so-called "terminal state" (1) or Arieti's "fourth stage" (2) of schizophrenia, might be largely due to the relative lack of social and physical stimulation on the typical "back-wards" rather than an inevitable end-state for so many schizophrenic patients.

Secondly, the improvement observed in most of these patients, after a relatively short period on the activity treatment, indicates that the so-called progressive regression of some schizophrenic patients is reversible and, therefore, is not necessarily accompanied by serious organic deterioration.

Summary

The purpose of this study was a further evaluation of an activity treatment program with 14 severely regressed male schizophrenic patients. The results showed that a two-year participation in the program produced improved intellectual functioning, a decrease in schizophrenic symptoms, and a consequent improvement in hospital adjustment. The practical and theoretical implications of these findings were discussed.

References

(1) Appel, K. E., Myers, M. J., and Morris, H. H. Complications, sequelae, and terminal states. In L. Bellak (Ed.) *Schizophrenia: a review of the syndrome.* New York: Logos, 1958.

(2) Arieti, S. *Interpretation of schizophrenia.* New York: Bruner, 1955.

(3) Bellak, L. and Blaustein, A. B. General psychotherapy, group therapy, and allied methods. In L. Bellak (Ed.), *Schizophrenia: a review of the syndrome.* New York: Logos, 1958.

(4) Farina, A., Arenberg, D., and Guskin, S. A scale for measuring minimal social behavior. *J. consult. Psychol., 21*: 265-268, 1957.

(5) Henderson, K. Objective evaluation of an activity treatment program for seriously regressed schizophrenic patients. *Can. psychiat. J., 5*: 100-107, 1960.

(6) Kamman, G. R., Lucero, R. J., Meyer, B. T., and Rechteschaffen, A. Critical evaluation of a total push program for regressed schizophrenics in a state hospital. *Psychiat. Quart.*, *28*: 650-667, 1954.

(7) Lorr, M. Multidimensional scale for rating psychiatric patients, hospital form. *Veterans Administration Technical Bull.*, No. 10-507, 1953.

(8) Siegel, S. *Nonparametric statistics.* New York: McGraw-Hill, 1957.

Résumé

Ce qui précède est le rapport d'une évaluation portant sur un programme d'activité thérapeutique qui a duré deux ans et qui a été administré à 14 schizophrènes du sexe masculin atteints de régression grave. Le programme comportait un régime intensif d'activités sociales, récréatives et professionnelles (stimulation totale).

L'étude avait pour but de savoir si les malades avaient conservé l'amélioration notée il y a un an.

On a évalué les effets du traitement au moyen des techniques suivantes: (A) tests d'intelligence; (B) échelle de notation du comportement; (C) histoire de travail du malade. Les résultats ont montré que la participation au programme avait produit un fonctionnement intellectuel, une atténuation des symptômes schizophréniques et une amélioration concomitante de l'adaptation au milieu hospitalier. Les malades avaient non seulement conservé l'amélioration réalisée, notée un an plus tôt, mais leur état avait connu une plus ample amélioration. Bien que douze malades soient actuellement employés à l'intérieur et à l'extérieur de l'hôpital, aucun d'entre eux n'a encore reçu son congé. Les malades manifestent encore, moins qu'en moyenne, de l'intérêt envers leur milieu, ils évitent encore la compagnie des autres et leur activité est encore inférieure à la moyenne.

L'interprétation des constatations vient appuyer la théorie que la régression et la détérioration progressive souvent observées dans les cas de schizophrénie remontant loin dans le passé, pourraient être attribuables au manque relatif de stimulation sociale et physique chez les "arriérés" typiques, plutôt qu'un état ultime inévitable du processus schizophrénique.

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REGULATIONS RELATING TO THE TRAINING REQUIREMENTS IN PSYCHIATRY

The period of training and study in Psychiatry required for eligibility for either the Fellowship or Certification examinations of the College should be organized under university auspices to achieve an overall psychiatric experience. This training involves a minimum of four years of approved training after the general internship.

Two of the years of advanced training must be spent with the resident involved in an intensive teaching experience in an organized training programme of a University Department of Psychiatry. During these two years there should be experience on the psychiatric service of a general hospital, experience in an out-patient clinic dealing with community psychiatric problems, experience in child guidance in psychosomatic medicine and on a neurological service and in other settings approved by the university to meet special needs. There should be also contact with other medical disciplines and with the basic specialties in Psychiatry.

The additional two years of advanced training provide a wider choice for the trainee. However, these two years of training must include at least six months and preferably one year in a hospital providing an opportunity for the study of the comprehensive care of psychotic patients for a sufficiently long period to permit the resident to observe the natural course of the illness and its treatment. During such time the resident would be receiving training in the techniques, understanding and proper utilization of long-term methods of therapy and gaining some experience in the medical-legal problems peculiar to this type of institution.

TRAINING REQUIREMENTS FOR FELLOWSHIP EXAMINATION IN MEDICINE MODIFIED FOR PSYCHIATRY AND CERTIFICATION EXAMINATION IN PSYCHIATRY

1. An approved general interneship of at least one year.
2. Four years of graduate training in addition to the general interneship.

   This period must include:

   (a) Two years of approved resident training in Psychiatry during which the trainee participates in the organized training programme of a University Department of Psychiatry (read preamble carefully).

   (b) Two further years of approved training which may include: (read preamble carefully)

      (i) One or more years of resident training in Psychiatry in an approved mental hospital.

      (ii) One or more years of further approved training as outlined under section 2(a), providing such training includes the necessary minimum experience in the treatment of psychotic patients.

      (iii) One year of approved resident training in Internal Medicine.

      (iv) One year in the full-time study of related basic science such as Neuroanatomy, Neurophysiology, Psychology or Sociology in a Department approved by the College.

      (v) Six months of approved full-time study of a related basic science and six months of approved resident training in Internal Medicine, Paediatrics or other branch of medical practice related to Psychiatry.

      (vi) One year in an approved course of study and training at a hospital or university centre in Canada or abroad.

      (vii) One year in a psychiatric specialty such as Child Psychiatry, Community Psychiatry or Research.

January 1961.

Book Reviews

The Ordeal of Gilbert Pinfold. Evelyn Waugh. Chapman & Hall. 1957. pp. 184. 12s. 6d.

This tale concerns a middle-aged author, Gilbert Pinfold, who, despite various sedatives, has been unable to sleep for weeks. During the long sea voyage he takes in the hope of recovery, he begins to hear voices which he identifies with people on board whom he is somehow able to hear on account of wiring faults in the ceiling. These hallucinations are ingeniously handled, as is the manner in which Mr. Pinfold responds to them. Mr. Waugh does not disappoint us here. For example, although Pinfold has often means of proving that overheard plots and threats have not really taken place, he rationalises discrepancies by concluding that the wires in his cabin are somehow linked up with the B.B.C. and that he has, in fact, been listening to radio plays part of the time.

The book would have been more interesting, however, had we known more about Mr. Pinfold's character in order to understand why he heard the particular things he did hear and the reasons for his recovery, which remain a mystery. Despite its defects as a story, however, this is a significant addition to the descriptions of psychoses by the recovered.

W. Clifford M. Scott, Montreal

"Jordi"—A Composite Case History. Theodore Isaac Rubin, M.D. The Macmillan Co., N.Y. 1960. pp. 73. $2.95.

Dr. Rubin introduces his work as follows:—"I have endeavoured to write a book which is scientifically correct. However, the main endeavour of the book is to convey the feeling, panic, suffering, and tragedy involved in mental disturbance and more explicitly in childhood schizophrenia. Disturbances of this nature are, at best, poorly understood illnesses".

Since this is a short book of only 73 pages, it was possible to have several senior members of our Children's Outpatient Clinic at the Toronto Psychiatric Hospital read it and give their impressions. All were favourably impressed by the form in which the book was written. The story is told, in non-technical language, as though we were seeing the world through the eyes, emotions, and the thought processes of Jordi. The contrast between the emotionally toned life-in-action vignettes of Jordi's experience, and the colourless technically worded case summaries, heighten the effectiveness of the method used to present a sympathetic study of an emotionally disorganized boy.

Judged as a work of art and granted artistic license, Dr. Rubin has written a creditable account of the terror, suffering and torture of mental illness. The author achieves his "main endeavour" in that the family's tragedy, the loneliness, fear, and isolation of the boy, as well as the sudden joy of his new-found discoveries of reality, are all poignantly presented.

Looking at the work from the point of view of a psychiatrist or worker in the field of mental illness, we must agree with the author that disturbances of this nature are, at best, poorly understood illnesses, and within this limitation, Dr. Rubin can hardly be expected to achieve his goal of being 'scientifically correct'. The most serious scientific error would be the failure to mention that he was working from one of many points of view, namely, the psychoanalytic frame of reference. The profound biological disturbances which are a feature of schizophrenia were not mentioned. The reference to therapy was that of formal psychoanalytical therapy which may be recommended in a specific case, but hardly one which would apply in most cases.

In all, the book has much to commend it. It is a short, readable, informative and

stimulating account of the apparently illogical behaviour of the schizophrenic child and ends with a message of hope for these children who seem so lost and forlorn.

EDWARD J. ROSEN, M.D.

Physicians for a Growing America. Report of the Surgeon-General's Consultant Group on Medical Education. U.S. Dept. of Health Education and Welfare. Public Health Service 1959.

The conclusions are: to maintain the present ratio of physicians to population as a minimal essential to protect the health of the people, an increase in the number of annual graduates from schools of medicine and osteopathy from 7400 to some 11000 a year will be necessary by 1975. Current plans of present and developing schools indicate that the number of annual graduates will increase from approximately 7400 to 7900 by 1965. Thus, the planned rate of growth is now decelerating in relationship to the need.

Of the 7800 physicians licensed in 1958 to practise for the first time in the U.S., 150 were graduates of Canadian schools and 1166 were graduates of other foreign schools.

The ratio "133 M.D.s and 8 D.O.s: 100,000 population" has varied little for decades. In 1958, 17% of physicians in practice were educated in schools outside the U.S.A. Ratio of applicants to admissions has remained static, but Medical School Deans report increasing difficulties in filling freshman classes with acceptable students. The proportion of students failing and withdrawing is increasing. The rate of increase in Ph.D. students considerably exceeds the rate of increase in medical school graduates.

Expenses for the basic operation of medical schools increased from $54,000,000 to $176,000,000 in the decade to 1958. Grant-supported research increased from $17,000,000 to $88,000,000 in the same period. Reimbursement to schools for the indirect cost of this research falls far short of meeting costs. Consequently, universities have to support research at the cost of medical education.

The Group's advice is that funds more in line with those available to subsidise various types of post-graduate education be made available to subsidise medical education. Existing medical schools should increase enrolment. States without a planning group should, on a co-operative basis with other states, form groups to plan two-year (i.e. schools equipped to give the first half of training) as well as four-year schools. When Federal financial aid for medical education becomes available, use of this should be co-ordinated with funds available for research and hospital construction.

In view of the preceding facts, the implications for the enrolment and education of an increasingly adequate number of psychiatrists is indeed a problem. Even though facilities are increasing, they are out of step with the rate of increase in population, and it is easy to miss the fact that the rate of growth of psychiatric facilities may be decelerating rather than accelerating.

W. CLIFFORD M. SCOTT, M.D.,
Montreal.

The Neurological Examination of the Infant. André-Thomas, Yves Chesni and Mme. S. Saint-Anne Dargassies. Edited by R. C. MacKeith, P. E. Polani and E. Clayton-Jones. Published by the Medical Advisory Committee of the National Spastics Society, London, 1960. pp. 50. 5s.

The first thing in understanding neurological disorders in the new born is to know what a new born infant can do and can not do. The studies of André-Thomas have added greatly to our understanding. This small book graphically demonstrates with appropriate description the motor development and reflex

activity of the new born and older infant. It is only fifty pages. It is well illustrated with lined drawings. The subject matter is clearly presented. It should be a very useful volume to have on a ward devoted to the care of infants.

J. P. Robb, Montreal

Search for security—and ethno-psychiatric study of rural Ghana. M. G. Field. Northwestern University Press. Evanston, Ill. 1960. $5.00.

Florence Nightingale once said that the trouble with nurses in the Crimea was that the ladies couldn't nurse, and the nurses weren't ladies. The same problem has dogged many cross-cultural studies of mental illnesses. The psychiatrists aren't anthropologists, and the anthropologists aren't psychiatrists. True, we are slowly acquiring a breed of psychiatrists like Laubscher, Carruthers, Yap and Lambo, who are beginning to put these studies on a firmer foundation. Many less sophisticated clinicians have been struck by the extraordinary cohesiveness of the great psychoses. Schizophrenia, for instance, seems almost impervious to cultural differences. It is recognizably schizophrenia from pole to pole. There are of course differences, but these seem to be little deeper than the substitution of radar and radioactivity in the 1940's and 1950's for the simpler electricity and radio of the previous decades. There are few satisfactory books on cross-cultural psychiatry, so that any addition to their ranks has to be given a welcoming scrutiny. One is glad that another has been written, but apprehensive lest it simply adds to the confusion.

Dr. M. G. Field, the author of Search for Security (1) is very well qualified for this exacting work. She is a chemist, an anthropologist, and a psychiatrist. In addition she has lived for many years in Ghana, appreciates and enjoys its people without that sentimentality and partisanship which one sometimes finds among less experienced scientists. Her detachment is not due to any lack of sympathy or liking, but simply a necessary part of her professional equipment.

The first 140 pages of her book deals with the cultural background of rural Ghana and it is surely a model of its kind. It should be read by every psychiatrist and social worker. Political students would certainly benefit from it and of course any person who wants to work in health fields in Africa will, I think, find it obligatory. Dr. Field writes very well. She has a crisp, workmanlike style which is both witty and informative and there is a gratifying absence of jargon in her book. At the very start she emphasizes that the myth of the noble savage glowing with health was eventually dispelled by careful medical observation which showed that, in fact, primitive people are usually ridden by a variety of horrible diseases, so careful psychiatric observation is dispelling the notion that mental stress and mental illness are the prerogative of "over-civilized" societies. I have rarely come across such a pungent and clear discussion of another culture, with particular emphasis on the day to day matters of living and dying.

Dr. Field's observations have theoretical repercussions which will have to be elaborated and further studied by others. It is, for instance, difficult to reconcile her account of the infancy and childhood of Africans in Ghana with the ideas still held by some psychoanalysts that deprivation in very early infancy plays a predominant part in the development of schizophrenia, or with the views of some social scientists who blame many of our troubles on the nuclear western family.

Most of her Africans are members of extended families who are richly endowed with an enormous collection of uncles, aunts, cousins, elder siblings, grandparents, etc. In infancy children have affection lavished on them. They are pampered and wholly adored, but

older children are treated far less indulgently. Indeed an African proverb runs "it is unpleasant to be a child" and this is certainly no over-statement for from being the darling baby, the youngster is lucky if he or she can get enough to eat. Dr. Field suggests that this catastrophic loss of affection, regard, and even nutrition, may play some part in forming the character of many West Africans, but this appears to have little effect on the incidence of schizophrenia which seems to be the usual 1% or so, and neither does it prevent the subvarieties of the illness from appearing in Ghana as elsewhere. But the rather vividly paranoid attitude of many normal people may well derive from this early inexplicable, but almost universal, fall from favour. She illustrates this typical outlook with a splendid collection of mottoes which truck drivers paint on the back, sides, and front of their vehicles and she glosses these with explanations of their meaning given by their owners.

"All in vain". (I'm well protected, so if envious people plot my downfall they will not succeed.)

"Kill me and fly". (If you do me any harm, you won't escape.)

"No one likes me". (No one likes me to have this lorry: they envy me.)

"Jehovah is my salvation". (No envious person can hurt me.)

"A man would look out". (I am wary of enemies.)

and then two phrases Elizabethan in their richness —

"Hatred has no medicine". (People hate me but it can't be helped.)

"Death takes no bribes". (Your money will not protect you from death if you do me any harm.)

One might suppose that in an atmosphere charged with such foreboding the Ghanians would be a sad and timid people. Quite the reverse. Although convinced that accident, illness and madness are alike in being due to evil supernatural influences, they are flexible, tolerant, cheerful, remarkably democratic, and able.

Dr. Field has some particularly interesting views on witchcraft. Her standpoint is much the same as that which John Wier and Reginald Scott took about 300 years ago when they courageously and humanely suggested that mental illness plays a very large part in what was then thought to be witchcraft. The self accusations of 300 years ago which often led to the stake are echoed now in Ghana where many depressed people ascribe their unpleasant experiences to their having become witches. As with the evil eye (Malocchio) one can become a witch in spite of one's self and without knowing it, and a depressed people need little to convince them that they are witches for it accords well with the wretchedness of an affective illness. Indeed, in our own culture, even without the convenient rationalization of witchcraft, some people accuse themselves of unforgiveable crimes and being the source of misfortune to others, and even to the universe. Luckily these Africans at their shrines impose humane and sensible penalties and so there are none of the horrors of 17th century Europe.

Like most cultures, the Ghanians have no doubt that madmen exist, and although madness like every other illness is ascribed to supernatural influences, they recognize that it is different from others. When Dr. Field asked to see madmen she was taken nearly always to see severely chronic schizophrenics. These rural people show a good deal of tolerance for aberrant and unusual behavior, but this does not mean that they are unaware of its oddity.

Her account of the social value of spirit possession is a classic in its own right. She suggests that social usefulness of this phenomena is easily misunderstood if it is seen out of context.

The last 300 pages of her book consist of case histories which I usually find

very tedious reading. But Dr. Field's collection is a really fascinating one. The histories are very well written and I don't think I skipped a page. While it goes without saying that this is essential reading for any psychiatrist who intends to work with primitive people, in my opinion it is obligatory reading for anyone studying for certification. Not only is it one of the most balanced accounts of the relationship between mental illness and culture, but it is so well written and readable. Briefly, it is one of those notable books which has a place in every departmental library, and which most of us should dip into from time to time to clarify our thinking on the cultural aspects of psychiatry.

H. Osmond, Sask.

Correspondence

The Editor,
Canadian Psychiatric Association Journal,

Dear Sir,

Your editorial of last July pointed out certain differences in attitude between psychiatrists employed full time in government services and those engaged in other activities. May I take this a little further and suggest that a large part of the misunderstanding (and even conflict) arises because the two groups have different value systems? The outlook of the conscientious independent has probably never been better expressed than in Burke's words to the electors of Bristol in 1774:

> "Your representative owes you not his industry only but his judgement; and he betrays instead of serving you if he sacrifices it to your opinion".

For the sake of argument we can exemplify the independent attitude by ascribing it to Universities. On the one hand a civil servant's sole raison d'etre is to carry out the Department's policy. Every civil servant has a right to expect that his security and status will not be determined on party political grounds, and in turn, every minister has a right to assume that his staff will not sabotage his policies because they have political or personal disagreements.

The University on the other hand has an entirely different set of loyalties. The "good" teacher or research worker is not one who necessarily teaches what his Professor teaches, or who always confirms his Professor's work (although let us admit at once that it may be more tactful to do so). The University seeks truth, not tact, and teaches new insights, not conformity. The university worker is expected to challenge established theory if he can validly do so, the civil servant is expected to conform to established policy. Conformity is loyalty in one, disloyalty in the other.

This becomes a conflict if one person serves both masters. The two masters need not both pay him; any professional man should subscribe to this "university" ethic. A doctor working for an organization may find that independence of thought and obligation to his patients is in conflct with his employer's expectations of him. It is fairly easy to define the legal aspects of this, the moral ones are less clear. This is frequently seen in mental hospital practice because this is confined almost entirely to governmental facilities. The civil-servant-doctor working in a backward hospital suffers a grave clash of responsibilities. As a civil servant he should say and do only what his Minister authorises and instructs him to do. However scandalous the conditions he is not allowed to make public mention of them. As a doctor, however, he should exert himself to the utmost on behalf of his patients. If the truth challenges established theory or practice he is obliged to state it because that is the obligation laid on him by his profession. Now it has been argued that everybody is working for the good of the patients and so there is no conflict. It is said that any subordinate who detects one has either neurotic problems about authority or is in league with the Opposition. To say the least, this is a naive argument. The trouble is that government departments are second only to Churches in their tendency to forget why they are there. Toynbee writes:—

> "One generic evil of an institution of any kind is that people who have identified themselves with it are prone to make an idol of it. The true purpose of an institution is simply to serve as a means of promoting the welfare of human beings. In truth it is not sacrosanct but is 'expendible'; yet, in the hearts of its devotees, it is apt to become an end in itself, to which the welfare of human beings is

subordinated and even sacrified if this is necessary for the welfare of the institution. The responsible administrators of any institution are particularly prone to fall into the moral error of feeling it to be their paramount duty to preserve the existence of this institution of which they are trustees."[1]

In practice, the likelihood of conflict is often lessened by "assortative mating" but unfortunately the psychiatrist who wishes to work in hospitals does not have the freedom of choice given to his colleagues in most other branches of medicine; virtually all psychiatric institutions are government operated. However excellent the institution there is often a chronic dissatisfaction; the man who is not overly concerned with "structural authority" will create anxiety and hostility among those who are. If he is forced to conform to arbitrary, rigid and (to his eyes) often irrelevant regulations, he will become apathetic or irritable.

The trend to nationalization is undeniable whether one agrees with it or not. As this trend continues, larger and larger areas will become involved in the conflict. (It is worth noting here the danger of confusing two types of organization. One can be called socialisation—which is based on democracy at all levels—the other, nationalisation—a structure of rigid hierarchy, which is autocratic at all levels except in its general direction by the electors). As both the Civil Servant and the professional man can justify their attitudes by high moral principles, the conflict is bitter, as it is in religious differences. Accusations of disloyalty, hypocrisy, unprofessional attitudes, materialism, political opportunism and so on are used because the proponents of each side do not realise that their criticisms are justified only within their own system of values. Only by recognising, and as far as possible separating, the responsibilities can this be avoided. It is doubtful if any aspect of medicine can be adequately practised under an authoritarian system, but at the very least an organization responsible for teaching and research should not be run like or by a government department. A civil servant cannot be allowed to sabotage government policy but a professional worker cannot be expected to desert his own search for, and expression of truth as he sees it, for fear of embarrassing the party in power or disturbing the permanent officials.

In my opinion the solution is for a considerable increase in government support for "approved" centres, which can operate independently. Approval must, of course, be given as freely as possible and once given should not involve detailed control.

John Rich, M.D., Ph.D.,
Toronto

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